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# **RESTRICTIVE TRADE PRACTICES COMMISSION**

**HEARINGS RELATED TO THE MANUFACTURE, DISTRIBUTION  
AND SALE OF DRUGS**

## **HEARINGS**

*HELD AT*

**TORONTO**

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**VOLUME 17 - 20**

**OCTOBER 19, 20, 23 and 24, 1961**

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**Transcriptions reprinted and distributed by the  
Canadian Pharmaceutical Association**



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Professor H.J. Fuller





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INQUIRY UNDER SECTION 2

OF THE COMBINES INVESTIGATION ACT

Relating to the manufacture, distribution and sale  
of drugs


By Director of Investigation and Research

Combines Investigation Act

COMMISSION:

C. RHODES SMITH, Q.C.	-- Chairman
A.S. WHITELEY, M.A.	Member of the Commission
PIERRE CARIGNAN, Q.C.	Member of the Commission
F.N. MACLEOD	Combines Officer, representing the Director of Investigation and Research

Proceedings of hearings commencing at  
10 a.m., Thursday, October 19th, 1961,  
et seq in the City of Toronto, in the  
Province of Ontario.



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1921

Toronto, Ontario,  
October 19th, 1961.

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--- On commencing at 10 a.m.

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THE CHAIRMAN: Ladies and gentlemen, we

will resume the hearing. I think we might interrupt Mr.

Conder for just one moment. Mr. Gaudry, I believe, has

some information we would like to have on the record and

he won't be able to be here this afternoon. I think we

might be able to interrupt Mr. Conder's presentation just

long enough for Mr. Gaudry to let us have the information

he spoke to me about last night.

MR. HUME: Dr. Gaudry is the Director of  
Research at Ayerst of Canada.

DR. GAUDRY: That is right.

THE CHAIRMAN: Yes, Dr. Gaudry.

DR. GAUDRY: This is in connection with the  
much rapidly increasing amounts of money for clinical  
investigation in Canada. I would like to say this,  
the Food and Drug administration in Ottawa is now request-  
ing that some clinical investigation be done in Canada  
before accepting new drug applications. This is one of  
the reasons why a lot more money has to be spent on clinical  
investigations than used to be the case a few years  
ago.

THE CHAIRMAN: Do you mean when the Food and  
Drug Directorate adopted this requirement?

DR. GAUDRY: Well, I don't believe that they  
adopted, but they completely changed their laws or principles,  
but they are just requesting more and more frequently  
that this be done. While a few years ago they accepted



1 applications based almost entirely on work done in the  
2 United States and in Europe, now they seem to accept them  
3 no more. I am not too sure it is in all the cases, but  
4 in most cases they seem to insist work be done in Canada.

5 THE CHAIRMAN: I am recalling that yesterday  
6 we had some evidence that in 1960 there was a very marked  
7 step-up in the amount that was being spent on clinical  
8 investigation, clinical research. I wonder if that is  
9 associated with any increase in the pressure, might I say,  
10 put on the companies by the Directorate.

11 DR. GAUDRY: Well, I think so, or partly,  
12 but of course there are more compounds, more new compounds  
13 being tested clinically and therefore more new compounds  
14 in Canada if the companies want to import them in Canada.

15 THE CHAIRMAN: That is all you wish to say?

16 DR. GAUDRY: That is all, sir.

17 MR. HUME: Perhaps for the assistance of  
18 anyone, Dr. Gaudry, I could say your comments are related  
19 to the table that appears on page 37 of the brief. I  
20 haven't any idea what page it is in the transcript. It  
21 can be located in that way.

22 THE CHAIRMAN: You haven't read the trans-  
23 cript yet?

24 MR. HUME: No, not yet.

25 THE CHAIRMAN: Yes, Mr. Conder, please  
26 continue.

27 MR. CONDER: The next section, Mr. Chairman,  
28 is the section on advertising and promotion.

29 ADVERTISING AND PROMOTION

30 As an auxiliary to the medical profession,



1 the pharmaceutical manufacturing industry has four main  
2 areas of responsibility:

3 1. To study and develop through research,  
4 new and improved forms of medication, and to discover and  
5 improve methods of producing these substances so that they  
6 are available in sufficient quantity to meet the needs of  
7 the profession.

8 2. To manufacture under controlled condi-  
9 tions for use by the profession all known medical substan-  
10 ces, and to ensure uniformity, safety and therapeutic  
11 effectiveness.

12 3. To distribute these substances to all  
13 retail pharmacies and institutions across the country  
14 immediately they are available, and maintain supplies.

15 4. To let the professions know immediately  
16 new discoveries and improvements are available, so that  
17 they may be included in the practitioner's armamentarium,  
18 and to ensure that the physician is kept aware of the  
19 availability of these new drugs.

20 These four stages are interdependent, in  
21 that they comprise a chain of continuity which ensures  
22 the nation of a constant supply of the latest and most  
23 effective medication available. No single stage is suffi-  
24 cient unto itself, without the other three. Nor can one  
25 stage be dropped without materially affecting the effi-  
26 ciency of the system, which is one of the finest of its  
27 kind in modern society.

28 This chapter deals with the communication  
29 stage, referred to as advertising and promotion. This  
30 area of endeavour has been subject to much criticism.





1 Yet it is vitally important to the physician who must in  
2 the best interests of his patients keep abreast of the  
3 latest progress in pharmaceuticals. It helps to reduce  
4 the time lag between discovery of a product and its uses  
5 in medical practice.

6 It has been said that 70 per cent of today's  
7 medical practitioners completed their internships at least  
8 10 years ago, when penicillin G, streptomycin and the  
9 toxic mercurial diuretics were the newest substances known.  
10 Many of the medicaments which these doctors learned about  
11 from their courses in materia medica have since become  
12 obsolete. The decade has brought with it the psychosomatic  
13 drugs, new steroids and new muscle relaxants, to name but  
14 a few major advances which have occurred in this brief  
15 span of time.

16 Accordingly, advertising not only promotes  
17 the companies' products but it also fills a real need by  
18 keeping the doctor informed of current developments in  
19 the field of pharmaceuticals. Of the many sources of  
20 information available to the profession, surveys indicate  
21 that the physician acquires about 95 per cent of his infor-  
22 mation on new drugs from detailmen, direct mail and medi-  
23 cal journal advertising, in that order of preference.

24 THE CHAIRMAN: Will you be giving us parti-  
25 culars of the nature of these surveys, how they are conduc-  
26 ted? 95% is a very high percentage.

27 MR. CONDER: I believe it comes within the  
28 next paragraph and I will comment on it at that time.

29 THE CHAIRMAN: What I am thinking is we had  
30 doctors who said some detailmen provided them with very



1 useful information and others didn't. If there is any-  
2 thing to that statement I wonder if it is usual or fairly  
3 common.

4 MR. CONDER: This statement is based on  
5 surveys conducted by the International Surveys Limited of  
6 Montreal which is a survey house which provides surveys  
7 to pharmaceutical manufacturing companies. In other words,  
8 they go and survey the profession and provide them with  
9 the information.

10 THE CHAIRMAN: I realise it is done by  
11 International Surveys of Montreal. I wondered how it was  
12 done, how they proceeded, if you could give us any infor-  
13 mation on that, how they would arrive at 95%, what they  
14 did to gather their information. Have you any particulars?

15 MR. CONDER: Yes, there are two ways of  
16 looking at the promotional activities as to where the  
17 doctors derive their information. In one way, for example,  
18 you can say to the doctor, which do you prefer? In this  
19 case they look at it from the other way, they attempted  
20 to determine where had the doctor first learned of the  
21 product, not what he preferred, where had he actually  
22 heard about the product first. These surveys showed as  
23 we show on the table on page 58 where the doctors first  
24 heard of the product.

25 THE CHAIRMAN: I understand that. The  
26 question came to me again they might first hear about it,  
27 but not hear very much, and then subsequently get a good  
28 deal of information from another source which might per-  
29 suade him to use the new product.

30 MR. CONDER: Oh yes, I agree with you there,



1 sir.

2 THE CHAIRMAN: You often see an advertisement  
3 in a newspaper, a full-page advertisement and it brings  
4 the name to your attention but perhaps you don't see much  
5 more than that.

6 MR. CONDER: That is true; the same would  
7 apply actually in any area. The detailman probably has  
8 more comprehensive information than would be initially  
9 available, for example, through direct mailing piece; of  
10 course I mean pure direct mailing without complete litera-  
11 ture attached to it or from a general advertisement which  
12 by nature of its limitation in space could only carry so  
13 much information. A doctor if he is interested in this  
14 product can get complete information supplied to him through  
15 the detailmen in the form of a brochure on that particular  
16 product and some of these brochures are rather extensive.  
17 I will be filing some as an exhibit later with the Commis-  
18 sion as samples. They could simply write to the medical  
19 director of the company asking for detailed information  
20 or he could just drop a note to the company saying please  
21 send me some complete information on this product. Again  
22 he may - this would probably in a small number of cases,  
23 he may again, for example, learn about the product in  
24 detail at a medical meeting where some clinical investi-  
25 gator or some other person gives information, a talk on  
26 this particular product or supplies a paper on it. That  
27 would be in a considerably small number of cases. The  
28 largest information on the product would probably come  
29 from the company.

30 THE CHAIRMAN: We were anxious to get as





1 accurate picture as we could on this point as well as  
2 others. I notice in your table that the number who heard  
3 first about the drug from medical papers is very small  
4 indeed.

5 MR. CONDER: Yes sir.

6 THE CHAIRMAN: Antidepressants 2%, and anti-  
7 biotics 2½% and none heard about antihistamines and  
8 diuretics that way. We have had one or two doctors, unfor-  
9 tunately we haven't had direct evidence from many doctors  
10 or from a medical association which have made any surveys  
11 of the methods in this connection, but we did have one or  
12 two doctors who said they relied chiefly on the medical,  
13 the official medical publications in which there would be  
14 a complete explanation, but in some instances they got a  
15 good deal of information from the detailmen. It is the  
16 proportions that are striking me here. The proportions  
17 are very high here for the detailmen, secondly, for  
18 direct mail and thirdly, for journal ads and almost insig-  
19 nificant for medical papers. That is why I would like to  
20 know as much as we can how they arrive at it, if it is  
21 only the source from which the doctors heard about it and  
22 has no relation to the effect it had on him, or how much  
23 they heard about it, it doesn't give us really all the  
24 information we would like to have to know what is important  
25 to doctors.

26 MR. CONDER: Mr. Chairman, when a new pro-  
27 duct, for example, is first introduced to the market the impor-  
28 tant thing from the viewpoint of the marketing company is  
29 to get that product brought to the attention of the doctor  
30 first, so the doctor is aware here is a new antidepressant,



1 for example. It is then for the doctor to find more  
2 information on it. In this case the initial job of the  
3 company is to bring it to the doctor's attention so the  
4 doctor is aware of the product and the name of the product.  
5 The doctor may be using another form of antidepressant at  
6 that particular time and it may not make an impact on him.  
7 He may be quite happy with the antidepressant he is using,  
8 but at the same time he may feel he would like to get  
9 further information on this particular product to compare  
10 it with his own experience in other products. It is in  
11 that particular area the company is very helpful. They  
12 produce, I would say, invaluable product brochures which  
13 explain this product in complete detail, they have complete  
14 clinical information and frankly in some cases or in most  
15 cases the clinical information contained in these brochures  
16 is even more extensive than some of the information which  
17 may appear in an article or a research paper published in  
18 a medical association journal because the journal is  
19 naturally limited to the amount of space it can give  
20 whereas the company can put in complete information, give  
21 full details of side-effects, toxicity and other factors  
22 in their brochure which is made available to the doctor.

23 THE CHAIRMAN: We can understand that quite  
24 well.

25 MR. CONDER: But it is initially...

26 THE CHAIRMAN: The position as far as this  
27 table is concerned is that the company has brought out a  
28 new product, developed a new product. The company is  
29 anxious to make it known and it is likely that either by  
30 direct mail or by detailmen or both the company will



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Conder

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1 begin to bring this to the attention of doctors well  
2 before any formal article will appear in medical papers.

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JW/hm

1 MR. CONDER: Yes sir, it could happen  
2 because there could conceivably be a time lag in the medical  
3 journal concerned. The medical journals -- I believe that  
4 any editor will attest to this -- that the medical journal  
5 invariably has a great backlog of information to publish  
6 in that journal. It is a matter of what the editor con-  
7 siders to be pertinent at that time insofar as the material  
8 he uses in that particular issue.

9 THE CHAIRMAN: So that it would be quite  
10 likely that the first bringing to the attention of the  
11 doctor the new drug would come from the company in one  
12 form or another.

13 MR. CONDER: Yes sir.

14 THE CHAIRMAN: But whether that constitutes  
15 95% of the information is not quite as clear. You say,  
16 "About 95% of this information on new drugs comes from  
17 detail men, direct mail and medical journal advertising".  
18 It struck me that from what some doctors have said to us,  
19 the very few we had, and it certainly was not sufficient  
20 to enable us to come to any conclusion on any general  
21 terms, but the few who have appeared said they relied  
22 somewhat more heavily on the medical papers than these  
23 percentages would seem to indicate.

24 MR. CONDER: Some doctors conceivably could,  
25 sir. It would depend on a number of factors, whether the  
26 doctor was involved such as Dr. Reardon out in Halifax  
27 who would be a general practitioner or a physician in  
28 practice as opposed to someone such as, for example, Dr.  
29 Gemmel in Winnipeg who may be more of a university  
30 professor than a practitioner.



1 MR. HUME: We also have with us Dr. R. W.  
2 Shepherd who is a medical director of one of the member  
3 companies, and he has indicated he may be able to throw  
4 a little light on this point that you are discussing.  
5 Perhaps if I could call on Dr. Shepherd now, this is Dr.  
6 Shepherd.

7 THE CHAIRMAN: You are a medical director?

8 DR. R. W. SHEPHERD: Yes I am.

9 THE CHAIRMAN: You understand the point  
10 under discussion?

11 DR. SHEPHERD: Yes.

12 THE CHAIRMAN: You are a medical director  
13 of which company?

14 DR. SHEPHERD: Ciba. I appreciate your  
15 wishing clear information on this, Mr. Chairman. It is  
16 a very difficult matter to supply clear factual information  
17 on, but as Mr. Conder was just saying, I think he was  
18 touching on a point which is very pertinent. That is,  
19 that the specialist in a large university centre may  
20 acquire a lot more information from scientific papers and  
21 medical meetings than his colleagues in the smaller centres,  
22 and particularly in the rural areas where they rely almost  
23 exclusively upon the material supplied to them through  
24 the industry.

25 I think this factor has to be taken very  
26 seriously into consideration, Mr. Chairman. Again I say  
27 it is difficult to be sure exactly where the doctor gains  
28 his total information about drugs. Certainly, the first  
29 information does reach him from the industry, because, as  
30 you pointed out, it has not yet reached the medical press.



1 Thereinafter he gains further information from medical  
2 readings and papers and colleagues and discussions, and  
3 so on, but if he wishes he has made available to him by  
4 the industry the most complete information which is  
5 available on that drug.

6 The industry makes a special point of  
7 gathering together all the papers and reports on any  
8 product that it is interested in, and it is very ready to  
9 make this available to any physician who wishes it.

10 I don't know if this has already been said,  
11 Mr. Chairman, but it is a difficult thing to say how any  
12 particular doctor, and all the more so, how any particular  
13 group of doctors informs itself completely about a drug,  
14 but there is no doubt that the first information comes  
15 from the industry, and thereinafter the full information  
16 on everything that has been done on that drug.

17 THE CHAIRMAN: There is no question they get  
18 it first in most instances from the industry, and they  
19 might get it when it is asked for, and sometimes it is  
20 provided without being asked. Definitely a great deal of  
21 detailed information about the new drugs is provided, but  
22 it was the proportion of it that struck me as perhaps not  
23 giving the full picture, because it relates to the source  
24 which they first hear about it. The information which  
25 persuades the doctors to use it may not be the first informa-  
26 tion he receives.

27 DR. SHEPHERD: That is true. There again I  
28 emphasize the importance of the media of the information  
29 from the industry to the doctor outside the larger centres.  
30 This is very often ignored by the medical profession in the





1 large teaching centres.

2 THE CHAIRMAN: Thank you, Doctor. I don't  
3 think there is any doubt they get a tremendous amount of  
4 useful information.

5 MR. WHITELEY: Mr. Conder, do you know how  
6 the International Service collects this information?

7 MR. CONDER: I believe they have a certain  
8 group which they might term a prescription panel, a group  
9 of physicians which they contact about specific products,  
10 and a survey based on that information determines the  
11 results which goes into the reports to the individual  
12 companies.

13 MR. WHITELEY: Do you know how large a  
14 group it is?

15 MR. CONDER: I have no idea.

16 THE CHAIRMAN: Would it be sort of a  
17 Gallup Poll?

18 MR. CONDER: Yes, something like that.

19 This is borne out in recent studies conducted  
20 by International Surveys Ltd., of Montreal which determined,  
21 among other things, where doctors first learned about  
22 specific products. As these surveys were confidential to  
23 companies subscribing to this service, the names of the  
24 products involved have been replaced by their therapeutic  
25 classifications, as follows:

26 MR. HUME: Can that be taken as read?

27 MR. CONDER: I was just going to suggest  
28 that, Mr. Chairman.

29 THE CHAIRMAN: That is perfectly all right.

30



DOCTORS' FIRST HEARD ABOUT PRODUCT FROM:

<u>CLASS OF PRODUCT</u>	<u>DETAILMEN</u>	<u>DIRECT MAIL</u>	<u>JOURNAL ADS.</u>	<u>MEDICAL PAPERS</u>	<u>OTHER</u>
Antidepressant	69.8%	22.6%	--	1.9%	5.7%
Antibiotic	71.4%	14.3%	9.5%	2.4%	2.4%
Antihistamine	66.6%	16.6%	12.5%	--	4.3%
Diuretic	67.3%	20.4%	10.2%	--	2.1%

It is obvious that detailmen and direct mail are the two greatest single sources of information, immediately followed by journal advertising. This is not a case of determining which media the doctor prefers, but rather the one that provides him with the earliest information, for this is the factor which determines the efficiency of any dissemination of knowledge. Many of us complain about television commercials, but we still realize that these commercials make our favourite programs available. They are used because they perform a useful selling function. The same applies to pharmaceutical information and advertising. Many complain about direct mail, for example, yet it serves a basic need for product information and as indicated is used by the profession for this purpose.

This triumvirate of pharmaceutical communications comprises within itself a unique method of ensuring that the doctor learns of a new discovery, and keeping him aware that the discovery is available. Generally, these three sources of information complement each other. A doctor is an extremely busy man. At given periods, he may not have the time to see a detailman, read a direct mail piece, or study his favourite medical journal.



1 But as these three sources appear before him at different  
2 times, the chances are that he will at least learn of the  
3 new product from one of the sources. Which one, cannot be  
4 determined in advance, particularly when you are attempting  
5 to reach thousands of doctors as soon as possible.

6 For this reason, many companies use all  
7 three means simultaneously with the hope that each doctor  
8 will at least learn of the new product from one source.  
9 This, however, is by no means the rule. Some companies  
10 do no direct mail advertising whatever on the grounds  
11 that detailmen are the best means of providing complete  
12 information to the doctor, and the fact that a large  
13 percentage of direct mail is discarded.

14 Other companies believe that direct mail  
15 is an efficient yet economical method of advising the  
16 doctor of the product. These firms point out that while a  
17 good percentage of direct mail may be discarded it is still  
18 the least expensive means of communication, costing as it  
19 does but a few cents per doctor. This variance in the  
20 use of direct mail was shown in a survey of mailings by 33  
21 companies over an eight-month period from January 1, 1960 to  
22 August 31, 1960:

23 These two columns in this table, Mr.  
24 Chairman, show the total number of mailings over the eight  
25 months and the number of companies in each category. You  
26 will notice that seven firms had up to four mailings over  
27 this eight-month period. Some had none and others went up  
28 to four mailings. The next category, seven to twelve  
29 mailings, seven firms had 7 to 12 mailings over the eight-  
30 month period. The next category, 6 firms had 15 to 26





1 mailings. The next category, 9 firms had 34 to 48 mailings,  
2 and in the last category 4 firms had from 83 to 131  
3 mailings over this eight-month period.

4 THE CHAIRMAN: I was thinking the one that  
5 had 131 mailings was very busy?

6 MR. CONDER: Yes sir.

7 THE CHAIRMAN: It is better than one every  
8 two days.

9	Total No. of Mailings over 8 Months	No. of Companies in each Category
10	0 to 4 mailings	7 firms
11	7 to 12 mailings	7 firms
12	15 to 26 mailings	6 firms
13	34 to 43 mailings	9 firms
14	83 to 131 mailings	4 firms

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EMT/hm 1 While the average per company was 27 pieces  
2 for the eight-month period, the average is not a sound  
3 figure in this case. It will be noticed that four firms  
4 sent out considerably more direct mail pieces during this  
5 period than all the other 29 companies combined. Yet it  
6 is conceivable that the advertising costs of these four  
7 firms may have been lower than the others in view of the  
8 minimal cost of direct mail itself.

9 Furthermore, this does not mean that each  
10 of these mailings went to every doctor in Canada during  
11 the eight-month period. Many of them were limited to  
12 specialists, such as anaesthetists or urologists. For  
13 example, a company may have two new products: a pediatric  
14 substance and a psychopharmacological preparation.  
15 Information on both products would not normally be sent  
16 to both pediatricians and psychiatrists.

17 THE CHAIRMAN: I suppose there is no way  
18 of finding out, Mr. Conder, how many the average recipients  
19 would get in the course of this eight-month period. The  
20 total number of mailings run to a great many?

21 MR. CONDER: Yes. We do comment on that  
22 later in our presentation, sir.

23 In addition, not all direct mail is product  
24 advertising. A good percentage is non-promotional in  
25 nature and we wish to leave with the Commission a sampling  
26 of this type of literature for later study. If we may  
27 have this entered as an exhibit, sir.

28 MR. HUME: This would be I think exhibit  
29 T7. Just leave it down on the floor. I just wanted to  
30 explain, sir, that we will send this in its package to your



1 offices in Ottawa unless you wish to open it here, in  
2 which case we will pick it up later and send it back.

3 Mr. Conder, you might describe what this  
4 is so that we can have it on the record.

5 MR. CONDER: This was a sampling of a type  
6 of promotional literature which went out to all companies.

7 MR. HUME: Went out to all companies?

8 MR. CONDER: I am sorry, went out to the  
9 medical profession during a specific period in 1960.

10 MR. HUME: Can you say the period?

11 THE CHAIRMAN: Apparently it has a number  
12 of items?

13 MR. CONDER: We will say from January 1960  
14 to August 1960. It is a form of non-promotional advertising  
15 as opposed to promotional advertising, and we introduce  
16 this, Mr. Chairman, as an indication that the companies  
17 do send out a considerable amount of what might be termed  
18 informational material which is not necessarily of a direct  
19 product promotional nature.

20 THE CHAIRMAN: There are quite a number of  
21 pieces of mailings here?

22 MR. CONDER: Yes, sir, there would be.

23 MR. FRAWLEY: All from one company?

24 MR. CONDER: No, from different companies,  
25 Mr. Frawley. It is a sampling of literature. It is by  
26 no means all of this type of literature distributed by  
27 our companies during that period, but it is just a sampling  
28 to give you an indication of the type of literature.

29 THE CHAIRMAN: It is not just from one  
30 company. If one company sends out that much, I don't know





1 how the doctors would ever read all they would get from  
2 all the companies. I think we understand what it is now.  
3 We will look at it and see how it adds up.

4 MR. CONDER: Fine.

5 Generally, direct mail fills a need not met  
6 by detailmen or medical journal advertisements. Most  
7 journals are issued monthly, and, while their closing dates  
8 for advertising copy are more than reasonable, there is  
9 a time lag involved. Even the Canadian Medical Association  
10 Journal which is published weekly has a closing date 28  
11 days prior to publication. It often takes detailmen  
12 introducing new products several months before they are  
13 able to visit all physicians in their territories.

14 Direct mail is the fastest means available  
15 for sending out product information and it is most  
16 economical, particularly when used in large quantities.

17 Medical journal advertising is also another  
18 important source of information for the doctor, yet it  
19 has been criticized as being flamboyant, misleading, and  
20 with no mention of contra-indications. It is a known  
21 fact that most Canadian journals carefully screen the copy  
22 for advertisements prior to insertion. It is also common  
23 practice for all major companies to have their copy  
24 reviewed by physicians before it is sent to the journals.  
25 In some cases, the copy is written by doctors, or, in the  
26 case of a new discovery, by a medical advertising specialist  
27 in collaboration with the company's director of research.

28 Visually, the so-called flamboyant pictorial  
29 style used in journal advertisement is not as unusual as  
30 it may appear to the uneducated eye. An advertisement to gain



1 readership must be more than a box of black type. It  
2 must carry a pleasant layout of copy, and to a higher  
3 intellect such as a professional man this layout must be  
4 in extremely good taste.

5               Secondly, it is usual practice to include in  
6 the advertisement a picture or design to improve the type  
7 layout. In journal advertising, the picture used invariably  
8 is intended to depict in some form the medical problem  
9 involved.

10               As a general condemnation of advertising  
11 copy has been submitted to this Commission, we have  
12 attached to this submission a copy of the August issue of  
13 Applied Therapeutics, and we would ask you to review with  
14 us some of the advertisement in this journal, as follows:

15               THE CHAIRMAN: We will mark this as an  
16 exhibit too. This will be T8.

17               MR. CONDER: Yes, sir.

18               The first ad on the inside front cover shows  
19 a man suffering anxiety and tension. We draw to your  
20 attention the heading; the product is for this very purpose.  
21 You will also notice that this ad indicates to the physician  
22 that the product is available only on prescription.

23               The next ad contains a semi-caricature of  
24 an obese individual. As might be expected, the product is  
25 for weight control. Here, there is a specific notation  
26 regarding contraindications with a suggestion for an  
27 alternative product.

28               MR. FRAWLEY: The same manufacturer or by  
29 another manufacturer?

30               MR. CONDER: This would be by the same



1 manufacturer, Mr. Frawley, yes, sir.

2 On the following page appears a photograph  
3 of grass or a straw-like substance which most certainly  
4 is indicative of an anti-allergenic product. This ad, as  
5 well as others in this journal, advises the physician  
6 that there is a more extensive medical brochure available  
7 on request.

8 THE CHAIRMAN: I am afraid I am a little  
9 non-susceptible to the suggestion in this particular ad --  
10 straw, anti-allergy. I won't say that most people wouldn't  
11 be impressed, but to me it just looks like a lot of straw,  
12 and it doesn't necessarily indicate anything about allergy  
13 or anti-allergy. However, I am not complaining about the  
14 ad.

15 MR. CONDER: Turning the page over, we find  
16 a few medical instruments to brighten a claim for an  
17 anti-bacterial infection substance. Here it states that  
18 tests in nearly 11,000 patients indicate "no cases of  
19 serious side-effects or toxicity were reported." Again  
20 turning the page, we find an experimental plate as the only  
21 bright spot of this advertisement, and we suggest that this  
22 straight-laced layout is the antithesis of flamboyance.

23 On page 586, we find an ad with no central  
24 illustration whatever. Note the sentence: "Literature  
25 and samples gladly supplied on request." The facing page  
26 contains what might be termed a special insert on a heavier  
27 stock of paper. Aesthetically, the illustration is in  
28 extremely good taste, indicating as it does an artistic  
29 conception of depression. The copy on the other side of  
30 this insert spells out in detail the side effects involved





1 and how they may be controlled, and specifically warns  
2 against the product being used in certain cases.

3 MR. WHITELEY: A layman would be puzzled to  
4 see this type of advertisement.

5 MR. CONDER: Most of the illustrators,  
6 Mr. Whiteley, that are used in connection with this type  
7 of work are medical illustrators who are specialized in  
8 producing this type of artwork to appeal to the medical  
9 profession. It is intended to appeal to a medical  
10 practitioner per se as opposed to a layman.

11 MR. WHITELEY: Yes, it puzzled me who that  
12 particular depression should be considered to appeal to  
13 in this fashion.

14 THE CHAIRMAN: High-ranking modern art.

15 MR. CONDER: One of the points involved is  
16 this, in any advertising, as you realize yourself, sir,  
17 when you pick up a magazine, whether you are a layman or  
18 a professional man, and even if you pick up a consumer  
19 magazine, you turn the pages of this consumer magazine,  
20 you may conceivably go by advertisement after advertisement  
21 until you come to an article. You may not read the  
22 advertisement at all. If all advertising were in block type  
23 with headings at the top, and with the caption "This is an  
24 advertisement", and they were all in block type, you would  
25 pass these by because there would be nothing to catch your  
26 eye to make you stop just for a moment to look at that  
27 advertisement, and this type of insert is aimed at that,  
28 to make a doctor stop, take a look, and say, "My, that is  
29 interesting", and turn back and read about it.

30 MR. HUME: Mr. Whiteley's reaction is exactly



1 what the designer wanted. He would be most pleased that  
2 his ad is being discussed. I don't think he cares what  
3 he is putting down as long as someone will look at it and  
4 complain about it and discuss it.

5 THE CHAIRMAN: That one does look like a  
6 spider.

7 MR. HUME: Of course, Mr. Chairman, the  
8 billboards that Canadian Packers put out some years  
9 ago, nobody could understand what they were, and later on  
10 Canada Packers indicated the design had no meaning whatso-  
11 ever, but they got more advertising out of that billboard  
12 than any other they had ever designed.

13 THE CHAIRMAN: I think Mr. Whiteley's question  
14 is the same thing that comes to my mind. To a layman like  
15 ourselves, this particular advertisement does not necessarily  
16 indicate depression.

17 MR. WHITELEY: What I had more in mind was  
18 the appeal to the depressed person. I am trying to think  
19 of some parallel situation in other professions where  
20 advertising of this kind would be used. I know in my own  
21 profession I can't recall anything of this nature which is  
22 used to appeal to the economists. It may be their particular  
23 breed.

24 MR. HANSARD: We certainly don't use that in  
25 the legal profession.

26 MR. CONDER: Possibly economists don't have  
27 to be sold on the value of products.

28 MR. HUME: The question that came to my  
29 mind, how many depressions there are of this kind. Apparently  
30 advertisers feel there is quite a pile.



1 MR. FRAWLEY: I suppose in a legal magazine  
2 you would have a picture of a garter to indicate the law  
3 was very elastic.

4 MR. CONDER: I can hardly visualize someone  
5 advertising in Lex, for example, to get a counsel.

6 MR. FRAWLEY: I don't know what they would  
7 be advertising. I suppose that is the case of "come into  
8 my parlour said the spider to the fly".

9 THE CHAIRMAN: It looks to me as if it is  
10 designed to make someone say "What is this all about?"  
11 That is what it looks like to me.

12 MR. CONDER: It is an eye-catcher actually.

13  
14 ---EXHIBIT T5:

August issue of  
Applied Therapeutics  
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MR/dpw

1 Two pages over, on 592, there is a double  
2 page ultra-conservative layout, advertising the introduc-  
3 tion of a new tranquilizer. Here, you will notice that  
4 this suggests that the doctor obtain complete information  
5 on "indications, dosage, precautions, and contraindica-  
6 tions", from either the company's detailman or medical  
7 director. Both are at the doctor's service for complete  
8 information.

9 The following page shows an ad for an anti-  
10 biotic. Rather than flamboyant, this picture is somewhat  
11 stereotyped and old-fashioned when compared to the usual  
12 lay magazine advertising, showing as it does the young  
13 patient, the worried mother and the doctor. But it is  
14 interesting enough to cause some doctors to pause for a  
15 moment when looking through the journal.

16 Again, on page 596, appears an ad for a  
17 cholesteropenic agent; a new product being released after  
18 eight years of developmental work at both the basic and  
19 clinical research levels. You will note that this ad  
20 offers the doctor a 20-page explanatory brochure for his  
21 further consideration.

22 This sir is an example of what I mentioned  
23 earlier about a company bringing to the attention of the  
24 profession the name and formulation of a specific new  
25 product, after which the doctor would then be expected to  
26 get complete detailed information which is available to  
27 him on request.

28 The next ad would be particularly appealing  
29 to a trout fisherman and, while this Jock Scott fly may  
30 seem irrelevant, it is certainly not so to the angler who



1 is susceptible to poison ivy or eczematoid dermatitis.

2 THE CHAIRMAN: This isn't suggesting that  
3 that particular fly that is illustrated here has anything  
4 to do with nasal troubles or dermatitis?

5 MR. CONDER: No sir. It's the thought  
6 behind the use of the fly and the fisherman on the stream  
7 who is probably more prone to contacting poison ivy than  
8 would be someone who is not a fisherman.

9 THE CHAIRMAN: Not when he is on the stream  
10 that he gets poison ivy.

11 MR. CONDER: When he steps out of it.

12 The following page is largely taken up by a  
13 photograph of turbulent water, advertising an established  
14 product of one of the most conservative houses in the  
15 industry, and one which is highly respected for its  
16 integrity. This example is unusual in that the copy is  
17 designed to tie in with the illustration instead of the  
18 other way around, such as the ad on the following page  
19 which shows an emblematic rigidity to denote the Parkin-  
20 sonian patient.

21 Turning over to page 619, what could more  
22 realistically carry the connotation of a prenatal supple-  
23 ment than this caricature of a stork. And we doubt  
24 whether this long-billed individual would carry a psycho-  
25 logical depth sufficient to brain-wash any obstetrician.

26 This explanation merely covers the first-  
27 half of this particular journal, and we will not belabour  
28 you with the remainder which are of the same pattern.  
29 But these advertisements are typical of this field of  
30 information. This journal is published by a commercial



1 house as compared with a medical society organ. But  
2 regardless of the implication left with this Commission  
3 by one witness, there is no difference whatever between  
4 the advertising which appears in this publication and  
5 that of the CMAJ, for example. Although commercial in  
6 nature, this journal has a high professional standing.  
7 Not only are its national board and consultants drawn from  
8 among some of the senior medical authorities in Canada,  
9 but its editorial board of independent physicians reviews  
10 the advertising which appears in the book.

11 Incidentally, while you have a copy of this  
12 excellent journal, you might be interested in reading the  
13 editorial which appears on page 595, referring to this  
14 Commission, particularly the last paragraph which reads in  
15 part as follows:

16 "We believe that well-conducted hearings  
17 of this kind are a useful procedure in any  
18 modern democratic society. We do not  
19 believe that uncontrolled statements made  
20 by persons who suffer from a high index of  
21 irritability are in the least helpful.  
22 For example we hear or read dramatic state-  
23 ments about the promotion methods of phar-  
24 maceutical houses. When one stops to  
25 reflect, criticism of this kind strikes  
26 very deep indeed into the structure of our  
27 Canadian community. Do we want our whole  
28 health system to abandon all individual and  
29 competitive activity? If we want drug  
30 manufacturers to stop competing with each





1 other for attention and sales then we must  
2 surely want state control of the industry...  
3 or so some of the statements made by members  
4 of our profession would lead us to believe!  
5 It seems most unlikely that this would be  
6 a generally acceptable view".

7 MR. WHITELEY: Do you recall whether this  
8 is one of the journals that one of the doctors that  
9 appeared as a witness said he has never found any reference  
10 to the publisher of this paper?

11 MR. CONDER: I believe that it may be in the  
12 same family of publications Mr. Whiteley.

13 MR. WHITELEY: Is there anything in this to  
14 indicate who publishes this journal?

15 MR. HUME: Perhaps I might look at it.  
16 Under the laws of libel they have got to show their publi-  
17 cation. You have got a copy?

18 MR. CONDER: Yes.

19 THE CHAIRMAN: A whole page on the editorial  
20 board.

21 MR. CONDER: There is a whole page on the  
22 editorial board.

23 THE CHAIRMAN: On page 583.

24 MR. HUME: Seccombe House publication is it  
25 not?

26 MR. CONDER: Seccombe House publication,  
27 yes, it is. I am sure it must be in here.

28 MR. FRAWLEY: Is that somebody's name or is  
29 that a synthetic word?

30 MR. HUME: Seccombe House was a Dr. Wallace



1 Seccombe who was the Dean of Dentistry at the University  
2 of Toronto who founded the publication many, many years  
3 ago called Oral Health and that has now developed into a  
4 very responsible and important commercial enterprise  
5 publishing Modern Medicine in Canada both in English and  
6 French and Applied Therapeutics and a great many other  
7 publications.

8 MR. WHITELEY: I see on the final page there  
9 is some information?

10 MR. CONDER: This states here "Applied Thera-  
11 peutics, the Journal of Practical Therapy is published  
12 monthly by Current Publications Limited at Seccombe House,  
13 443 Mount Pleasant Road, Toronto 7, Canada".

14 Furthermore, lest there be any mistake about  
15 the medical profession's views concerning pharmaceutical  
16 advertising, we submit for your consideration the following  
17 editorial which appeared in the Canadian Medical Association  
18 Journal on March 25, 1961:

19 "Berating the pharmaceutical manufacturers  
20 has become a highly popular pastime. Some  
21 of the criticism levelled at the industry  
22 seems valid and constructive; a considerable  
23 proportion is unfounded and misleading. The  
24 pharmaceutical industry's contribution to  
25 the conquest of disease, the betterment of  
26 health and the remarkable advances in every  
27 facet of science and practice of medicine,  
28 beyond doubt, has been a major one. In  
29 this endeavour the pharmaceutical manufac-  
30 turer has been and should continue to be a



1 close and trusted ally of the physician.  
2 His role in this partnership involves the  
3 development, testing and perfection of a  
4 rapidly increasing range of pharmaceuticals.  
5 Those that meet the high standards demanded  
6 of them are launched in a highly competitive  
7 market where they must be sold to survive.  
8 A good product will achieve satisfactory  
9 sales if it is therapeutically beneficial  
10 without deleterious effects, but it will  
11 not become widely used unless it is widely  
12 known. This, perforce, involves advertising  
13 and since ethical pharmaceuticals are  
14 largely or entirely dispensed on the advice  
15 of physicians the advertising must logically  
16 be directed to physicians. The quality of  
17 such advertising may be good, or it may be  
18 bad. Since the physician is its major  
19 target, it is reasonable that he should  
20 voice his opinions concerning those features  
21 of pharmaceutical advertising that he  
22 considers detrimental. In Canada he has  
23 done this rather bluntly, through the  
24 proper channel, his professional organiza-  
25 tion.  
26 It also seems logical and obvious that the  
27 pharmaceutical manufacturer would be  
28 interested in the reactions of the target  
29 of his advertising. By no means does this  
30 deny the value of sound, reliable



1 advertising of ethical pharmaceutical  
2 products, which, on the contrary, has  
3 become more important than ever before.  
4 The concern of the medical profession  
5 emphasizes its recognition of this fact.  
6 Pharmaceutical advertising has had and  
7 will continue to have considerable educa-  
8 tional influence on the practising physi-  
9 cian. It behooves the medical profession  
10 to work in harmony and mutual understanding  
11 with the pharmaceutical industry to raise  
12 the standards of this, as well as other  
13 aspects of graduate medical education".

14 The editorial refers to the fact that the  
15 Canadian Medical Association advised us of some features  
16 of advertising which it considers detrimental. This was  
17 immediately brought to the attention of member companies.

18 As was mentioned in the CMAJ, a broad and  
19 generalized criticism against pharmaceutical advertising  
20 is not valid. There is very definite need for this system  
21 of communication. It is essential to the dissemination  
22 of pharmaceutical information and it maintains the compe-  
23 titive nature of the industry. Companies do not spend  
24 money unnecessarily, and if there were a more efficient  
25 and effective means of reaching the doctor other than  
26 through detailmen, direct mail and journal advertising,  
27 the industry would have found it by now.

28 THE CHAIRMAN: Mr. Conder, in that connec-  
29 tion one feature that some of our earlier witnesses, the  
30 doctors, brought out and it appears from some of your





1 tables, and that is the volume of direct mail advertising  
2 which some doctors said was quite impossible for them to  
3 read.

4 One said that he would do nothing else but  
5 read literature that came in if he read it all. He would  
6 be all day reading it.

7 One wonders whether the volume has not got a  
8 little bit out of hand from the point of view of being  
9 really effective. I wonder if your Association had had  
10 any studies made on that point? Whether your member  
11 companies had felt that there is something that might be  
12 done to keep the volume of this material from continually  
13 growing; whether they thought it was getting to the point  
14 where it was not as effective as it should be?

15 MR. CONDER: I know that some companies are  
16 examining very closely this so-called advertising mix of  
17 direct mail, detailmen and journal advertising, plus other  
18 ones that come into it and are revising some of their  
19 thinking and some of their operations on it.

20 There can be no doubt, as we mentioned  
21 earlier and showed by that table that some companies  
22 definitely use considerably more direct mail than others.

23 Other companies use no direct mail whatever.  
24 I would say the majority of companies, the great majority  
25 of companies in this industry do a direct mail job which  
26 might be considered really on the low side. Some companies  
27 do heavy direct mail. These companies feel, as I mentioned  
28 earlier, that by the very fact that they are able to use  
29 direct mail and the fact that this brochure costs a matter  
30 of cents for doctor reached, it pays them from the dollar



1 viewpoint to send out direct mail rather than to pay more  
2 detailmen in contacting them.

3 THE CHAIRMAN: We understand the argument  
4 here. We are clear on that. What I was getting at is  
5 whether the total volume of this direct mail advertising  
6 which goes to the doctors is reaching such proportions  
7 that it is losing a great deal of its effectiveness. Is  
8 that correct, or what is the position?

9 MR. CONDER: It is the position of a doctor  
10 in this case, and I imagine it applies in any field of  
11 endeavour - I know that certainly in my day-to-day busi-  
12 ness I receive a considerable amount of direct mail from  
13 various suppliers who are supplying our particular field  
14 with information, services and equipment - but the doctor  
15 does not have to read direct mail. Direct mail going into  
16 a doctor's office goes first into his receptionist or  
17 nurse. If the doctor says I won't read any direct mail  
18 whatever, then he doesn't have to look at it.

19 THE CHAIRMAN: That is the point I am getting  
20 at. It is losing its effectiveness if the doctors don't  
21 read it.

22 MR. CONDER: That is true but if the doctors  
23 did not read the literature, the company would not send it  
24 out.

25 THE CHAIRMAN: Provided they knew that fact.

26 MR. CONDER: We find, for example, we have  
27 many instances where a company introducing a new product  
28 will initially introduce this product through various  
29 advertising means and probably one of the first to arrive  
30 on the doctor's desk will be a direct mail piece. As a



1 result of these direct mailings they get back a considerable  
2 number of requests for further information on the product  
3 which could have come only from this particular mailing.

4                 Quite often the mailing literature will  
5 include a little reply card. The little reply card will  
6 state "Please send me a sample of this product and complete  
7 product information". This card is then placed in the  
8 mail by the doctor. When the company receives it they  
9 send the information, plus a sample of the product so that  
10 he may study that sample in practice.

11                THE CHAIRMAN: I suppose the position, as  
12 far as you are able to state it, would be this growing  
13 volume of direct mail advertising results in many doctors  
14 not reading it. Nevertheless, there is enough of it  
15 read it is worthwhile to continue to send out direct mail?

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/PB/hm

1 MR. CONDER: Yes sir. I think it is a  
2 principle of advertising in general that regardless of  
3 what form of advertising it may be, professional or lay,  
4 there is a considerable portion of the readers or people  
5 who receive this particular form of advertising who pay  
6 little or no attention to it, some dislike it, others like  
7 it and others are neither here nor there. As long as that  
8 advertising does produce a certain percentage of results  
9 then it is worth the time of the company concerned.

10 MR. HUME: You will recall Mr. Thompson  
11 in his evidence with respect to direct mail advertising to  
12 10,800 doctors said he got 25% returned. There was a card  
13 to check and the doctor had to sign his name. That evidence  
14 was on Monday or on Tuesday. It would be an indication,  
15 I think, of a very high ratio of direct mail returns  
16 according to what I read in a publication regarding direct  
17 mail.

18 THE CHAIRMAN: In that instance it would be  
19 correct.

20 MR. HUME: It would indicate 25% of the  
21 doctors thought enough to do something about it and who  
22 knows how many thought about it and did nothing.

23 THE CHAIRMAN: That was the one quite  
24 striking instance.

25 MR. HANSARD: There is a new method now of  
26 trapping the unwary recipient of mail. They are now sending  
27 out advertising material that looks like bills in the hope  
28 you will open it. My mail when I get home every night  
29 consists of great amounts of direct advertising stuff and  
30 bills and now the direct advertising are trying to make





1 their stuff look like bills on the outside in the hope you  
2 will open it.

3 THE CHAIRMAN: Some are a little more  
4 ingenious. They make it look like a cheque.

5 MR. HANSARD: It never happens to me.

6 MR. CONDER: Promotion in this industry is  
7 costly in relation to lay advertising, because of the calibre  
8 of the information required and the technical nature of  
9 the data involved. Pharmaceutical literature must be  
10 carefully prepared, screened by medical men, and presented  
11 in a manner that is quickly and clearly understood by  
12 the doctor. In addition to the advantages inherent in the  
13 product, the literature must also indicate the nature and  
14 action of the product, the administration and recommended  
15 dosage, and the contraindications, toxicity and precautions  
16 involved. By the very nature of these technicalities, the  
17 same dollars used in advertising pharmaceuticals will not  
18 bring back an equivalent ratio of readership or impact as  
19 does lay advertising.

20 The educational requirements for a detailman  
21 are probably higher than that for salesmen in most other  
22 fields, primarily because it is essential that he have  
23 a higher education and training in order to provide the  
24 answers required by physicians and pharmacists. The large  
25 majority of detailmen have university degrees. There is  
26 a definite shortage of graduate pharmacists for detailing.  
27 While a company may prefer pharmacists for this role, they  
28 are not always available. Consequently, the company may  
29 have to take someone with a non-pharmaceutical background.

30 THE CHAIRMAN: I suppose you haven't any



1 figures as to the proportion that are fully trained pharma-  
2 cists or that are trained graduates in medicine or have  
3 some other years of training in the same area.

4 MR. CONDER: Detailmen in Canada will not  
5 be graduates in medicine at the doctorate level, detailmen.

6 THE CHAIRMAN: They won't be.

7 MR. CONDER: They wouldn't be as a rule.  
8 There undoubtedly have been exceptions to this in the past  
9 because, I believe, it is the practice in some European  
10 countries, but in this case we had a survey made some time  
11 ago -- unfortunately I don't have the figures here with  
12 me. It applies to the ratio of detailmen holding degrees  
13 such as Bachelor of Pharmacy, Bachelor of Science or  
14 possibly pre-med education and other degrees of that level,  
15 it is about 8 to 12. The ratio would be 8 to 12. Eight  
16 with pharmacy or science as against 12 for the total.

17 THE CHAIRMAN: Two-thirds of them would have  
18 degrees in science or some pre-med or equivalent training;  
19 is that it?

20 MR. CONDER: Yes, they would be primarily  
21 pharmacists if you held one figure above the other. It  
22 would be primarily Bachelor of Science or its equivalent  
23 depending on the university granting the degree.

24 THE CHAIRMAN: Your survey indicates about  
25 two-thirds of all detailmen have some training of that  
26 kind?

27 MR. CONDER: Yes sir.

28 THE CHAIRMAN: When I say some, I don't mean  
29 a very short course, some substantial training.

30 MR. CONDER: Formal training at the university



1 level before commencing with the company.

2 Doctors will not generally prescribe new  
3 products solely on the recommendation of the manufacturer.  
4 They require complete information in order to evaluate  
5 the product's use in practice. If the doctor knows from  
6 experience the company concerned has a reputation for  
7 reliability in introducing new substances, then he will  
8 undoubtedly ask the company's local representative for the  
9 required background information. In this manner, the  
10 detailman serves as an important contact between the  
11 practitioner and the manufacturer, and it is his primary  
12 function to acquaint the doctor with the limitations as  
13 well as the capabilities of his company's products.

14 Criticisms have been levelled before this  
15 Commission with the connotation that companies and their  
16 detailmen attempt to hide or minimize contraindications.  
17 This is incorrect, as will be shown in this sampling of  
18 literature containing specific references to contra-  
19 indications, which we wish to leave with the Commission  
20 for later study.

21 May we have that entered as an exhibit,  
22 sir?

23 MR. HUME: With your permission, Exhibit T8.

24 THE CHAIRMAN: It would be T9.

25 MR. HUME: It is a sampling of direct mail  
26 advertising containing reference to contraindications, is  
27 it not?

28 MR. CONDER: That is correct.

29 MR. HUME: Which, Mr. Chairman, we will again  
30 undertake to see is delivered to your Ottawa office.



1 ---EXHIBIT T9:

Sampling of direct mail  
advertising.

2

3 THE CHAIRMAN: We have had the criticism  
4 directed that detailmen are salesmen and that as salesmen  
5 they are concerned about making sales and that is their  
6 most important interest and in some cases they may have  
7 reason to play down or not play up the possible drawbacks  
8 or dangers in the use of a particular drug that they are  
9 bringing to the attention of the doctor. I think that  
10 is what it amounted to.

11

MR. CONDER: Yes sir.

12

13 THE CHAIRMAN: Some of the criticism went  
14 further than you would think justified.

15

16 MR. CONDER: As Mr. Thompson of Cyanamid  
17 mentioned very briefly in his presentation to you on  
18 opening day his company recalled -- he mentioned small  
19 cards which he left with you, and the detailman passed the  
20 card and there is further information such as the 20-page  
21 brochure I mentioned earlier which is available to doctors.  
22 This information is made available to the doctors. It  
23 definitely shows contraindications. We have filed  
24 samplings of literature. This material is either sent to  
25 the doctor when he writes into the company for information, or  
26 in some cases it may actually be a small explanatory card  
27 which goes into the doctor's file and may be attached to the  
28 piece of direct mailing when the direct mail goes out,  
29 but the detailmen carry them with them so he gives it to  
30 the doctor when the doctor asks him about the product which  
he has possibly read about from brief mention in a medical  
journal. The detailmen will invariable leave the informa-





1 tion with him. This is the method in which this particular  
2 material is brought to the attention of the profession.

3 As might be expected, all detailmen are  
4 not perfect. Their abilities in detailing depend upon  
5 their individual capabilities, as it is in any field of  
6 endeavour. But it is safe to say that the great majority  
7 are well-trained, intelligent individuals who provide a  
8 tangible service to the medical profession. This is  
9 indicated by the fact that surveys show the doctor  
10 considers the detailman to be his front line of information.

11 The charts on pages 108-110 of the green  
12 book indicate that the cost of detailmen averages out to  
13 less than 15 per cent of the sales dollar. The Clarkson  
14 Gordon & Co. survey indicated 14.1 per cent for 40  
15 companies. Using this figure as an average, you would save  
16 not more than 9 per cent of the sales dollar by eliminating  
17 the practice of detailing. The reason for this is that  
18 most detailmen spend only part of their time in calling  
19 on doctors. The other part is spent in visiting retail  
20 pharmacies and hospitals, general servicing for the  
21 company, serving as an on-the-spot point of contact for  
22 clinical investigators, and other miscellaneous duties  
23 which are essential to any national company. This was  
24 borne out by the survey conducted by Clarkson Gordon &  
25 Co., which showed that detailmen spend a weighted average  
26 of 36 per cent of their time on duties other than detail-  
27 ing doctors.

28 MR. WHITELEY: Where is the information from  
29 the Clarkson Gordon survey?

30 MR. HUME: Clarkson Gordon has this survey.



1 It is information they reported to us as a result of the  
2 survey. They conducted an independent survey outside the  
3 Association with certain questions we thought might be  
4 useful. This is the report they gave us from that survey.  
5 We don't have the survey available, do we?

6 MR. CONDER: Actually this survey was  
7 undertaken for the Ontario Government Select Committee on  
8 Drugs to give them further information which they had  
9 requested at a subsequent hearing, which is yet to be held.  
10 Clarkson Gordon is not as yet finished the results of that  
11 survey. We have taken parts that were available from them  
12 and included it in here.

13 MR. HUME: Perhaps what Mr. Whiteley means  
14 is do you have a letter from Clarkson Gordon to corroborate  
15 your figures?

16 MR. WHITELEY: How do you fit this into the  
17 information given on pages 17 and 18?

18 MR. CONDER: This was a supplemental question  
19 asked by Clarkson Gordon & Co. and this is the result that  
20 they had.

21 MR. HUME: It would fit in, if you turn to  
22 page 17 that shows wages and salaries at a figure of  
23 31 million odd. That would include the wages and salaries  
24 of detailmen, but it also included the salary of the  
25 president. Clarkson Gordon went on and asked questions  
26 about the number of hours the detailmen spent in detailing  
27 doctors and this is the answer they gave us as being the  
28 weighted average. It is not intended to fit into the  
29 survey on page 17. It is further information. The question-  
30 naire was a very extensive document. It had information



1 other than what is reflected on page 17.

2 THE CHAIRMAN: The question arises where  
3 we are using this material or a portion of it of Clarkson  
4 Gordon, whether we should have the report.

5 MR. HUME: There is no hesitation....

6 THE CHAIRMAN: It is not available.

7 MR. HUME: It is not completed. This  
8 information was obtained for the purpose of preparing the  
9 brief. I speak for Mr. Conder, do I not, that as soon as  
10 we have that available from Clarkson Gordon, the entire  
11 report, the copy will be available immediately.

12 MR. CONDER: We would be very happy to.

13 MR. HUME: It is due tomorrow or Monday?

14 MR. CONDER: I would certainly hope it will  
15 be.

16 MR. HUME: My latest instructions were it  
17 will be finished by the end of the week.

18 THE CHAIRMAN: They indicate apparently  
19 that 36% of the time of detailmen on the average, weighted  
20 average, is spent on duties other than selling duties?

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1 MR. CONDER: Yes sir, it is varied.

2 THE CHAIRMAN: A good deal of that would be  
3 spent in calling on pharmacists and hospitals and showing  
4 them the particular drugs?

5 MR. CONDER: Yes, that is correct, or in  
6 some cases actually taking obsolete stock and material,  
7 depending on how the company handles this. We have  
8 different policies.

9 THE CHAIRMAN: I was thinking insofar as  
10 extending the use of values and possible drawbacks of the  
11 drug to the hospital or to the pharmacist. It would be  
12 very much the same as detailing doctors.

13 MR. FRAWLEY: Yes.

14 MR. HUME: Except the reason we started it,  
15 with respect, is that the doctor is the one who prescribes  
16 it. You can describe it to the hospital, but it is not  
17 the hospital that writes the prescription. The purpose  
18 was to indicate that the actual selling, the man who  
19 writes the ticket 36% of the time, amounted to this figure,  
20 but it is only a weighted average.

21 THE CHAIRMAN: But it is part of their  
22 sales activities. They go to pharmacists and tell them  
23 that they are dealing with the doctors and they'd better  
24 get ready for an influx of orders.

25 MR. HUME: Yes, I imagine so.

26 MR. CONDER: It is rather interesting to  
27 note, and I base this, as I said, Mr. Chairman, on the  
28 fact that Clarkson Gordon Company has prepared this parti-  
29 cular figure, and they had a range which varied only from  
30 a low to a high. They said it would amount to around a





1 40 to 50% area.

2 I mentioned we would like to use this  
3 figure for representation before this Commission, and  
4 as a result of that, they took a definite weighted  
5 average and it came out to 36%.

6 THE CHAIRMAN: Thank you.

7 MR. CONDER: The question is whether this  
8 saving of about 9 cents on the manufacturer's sales  
9 dollar, would be worth the undoubtedly adverse result  
10 which would occur by depriving the medical profession of  
11 its foremost source of product information.

12 Sampling is another practice followed by  
13 the industry when introducing products to physicians.  
14 The objective is to give these to doctors so that they  
15 can evaluate the drug's usefulness. These samples are  
16 often given to patients as "starter doses" to be used  
17 until the patient can have a prescription filled. A  
18 number of physicians use samples for their indigent  
19 patients, and some companies actively support this prac-  
20 tice.

21 The tables on pages 108-110 of the green  
22 book show a considerable variation in the percentages of  
23 sampling costs to sales. We are reasonably certain that  
24 the higher percentages reflect more costly products such  
25 as the antibiotics. And these product samples are the  
26 very ones which the doctor will keep in his bag for night  
27 and emergency calls. Doctors do use samples, and it  
28 would hardly be practical to expect the physician to buy  
29 these products himself.

30 A statement was made before this Commission



1 in Calgary by a newspaperman about a doctor who receives  
2 "about \$2,500 worth of samples from drug companies each  
3 year". This figure is too high by at least \$2,000.

4 We asked our companies for the average cost  
5 per doctor of all samples distributed during the year 1960.  
6 Thirty-nine firms reported a total of \$285.17 for an  
7 average of \$7.31 per company over the 12-month period.  
8 These are all major companies in the industry, and it is  
9 doubtful that the remaining firms would produce another  
10 total of \$214.83, which means that the total cost per  
11 doctor sampled in 1960 was much less than \$500.

12 Nor does this mean that all doctors in  
13 Canada received \$285.17 worth of samples from these 39  
14 companies. Many of these samples were restricted to  
15 specialists, while others were distributed only on request  
16 to a limited number of practitioners. Consequently, the  
17 average for all doctors in Canada would be considerably  
18 lower.

19 The green book quotes on page 111 an  
20 excerpt from Harper's Magazine referring to the "lavish"  
21 gifts to doctors by pharmaceutical firms in the United  
22 States. To determine the extent of this practice in  
23 Canada, we polled the same 39 companies for information  
24 on their practices in this respect during 1960.

25 Of these 39 companies only one distributed  
26 a gift to all doctors in 1960. Eighteen firms gave no  
27 gifts whatever during the year. The remaining 20 companies  
28 reported as follows: Nine limited distribution to  
29 graduating medical students and interns, 10 gave gifts on  
30 a limited basis to certain practising physicians, while



1 one gave a pencil and map to delegates attending the  
2 British Medical Association convention in the U.K.

3 In all, the average cost per unit of these  
4 gifts was \$1.29. Gifts to practising physicians ranged  
5 from calendars and pocket diaries to pencil holders and  
6 ball point pens, at an average cost per unit of .82¢ each.  
7 Graduating medical students and interns were the major  
8 recipients, receiving introductory product kits, thermo-  
9 meters, diagnostic lights, business cards, etc., for an  
10 average per unit cost of \$2.19 for the year 1960.

11 THE CHAIRMAN: We had one example of that  
12 filed with us in one of the western cities, I have just  
13 forgotten which one it was now, and it looked to be more  
14 than \$2.19, but the average is \$2.19?

15 MR. CONDER: The average is \$2.19 because  
16 we have seen some of them sent out that would cost 4 cents  
17 each.

18 It is recognized that a comparatively small  
19 percentage of firms use this type of gift in Canada, and  
20 it is obvious from the per unit costs involved that they  
21 are by no means "lavish". Incidentally, it is known that  
22 promotional practices of this nature are more prevalent in  
23 the United States, although it is doubtful whether the  
24 claims being made about that industry's operations are  
25 any more factual than the ones being directed against us  
26 in Canada.

27 The company mentioned in the green book as  
28 having provided plant tours of its U.S. company for  
29 graduating medical students is not a typical undertaking  
30 by companies in Canada. However, some of our companies



1 do arrange plant tours of their own Canadian facilities  
2 from time to time.

3                 This has been criticized as further "brain  
4 washing" of doctors. But if pharmaceutical manufacturing  
5 is the profession's major supplier, then it stands to  
6 reason that physicians should have a first-hand knowledge  
7 of how drugs are produced and under what conditions. We  
8 wish that more of our companies would use plant tours for  
9 this purpose, if for nothing but to dispel the impression  
10 being created that pharmaceutical manufacturing is nothing  
11 but a few tableting machines in a small room.

12                A large plant is a fascinating operation,  
13 particularly to someone who is scientifically inclined  
14 and, as was stated before the Ontario Inquiry, if every  
15 Canadian could tour a well-regulated pharmaceutical plant  
16 there would no longer be the misconceptions concerning our  
17 industry which have become prevalent in recent years.

18                Such a tour is essential to a complete under-  
19 standing of our industry and we extend to the members of  
20 this Commission a cordial invitation to visit a few plants  
21 in Montreal, which is the nearest major centre to Ottawa.  
22 We will be pleased to make the necessary arrangements at  
23 your convenience.

24                Before concluding this chapter on adver-  
25 tising, we wish to comment briefly on a couple of state-  
26 ments made before this Commission by Dr. J.P. Gemmell in  
27 Winnipeg.

28                This witness stated that physicians in the  
29 United States receive about 4,500 pieces of direct mail  
30 per year and that the amount in Canada is not too





1 "dissimilar". We do not know whether the U.S. figure is  
2 authentic, but we do have evidence which shows conclu-  
3 sively that the amount in Canada is less than half that  
4 figure.

5                   According to the Medical Mailer for March,  
6 1961, produced by Canadian Mailings Ltd., of Toronto:  
7 "The English-speaking doctor (in Canada) received a total  
8 of 2,147 pieces of mail advertising during the year 1960".  
9 Nor was all of this literature from pharmaceutical houses.  
10 The same reference indicates that 18 per cent of this  
11 literature was from suppliers of books, journals and  
12 equipment, plus general solicitations. Deducting this 18  
13 per cent from the total mailings received by a doctor in  
14 the course of a year means that he actually received  
15 1,761 pieces of literature from pharmaceutical houses,  
16 which most certainly is a far cry from 4,500.

17                   By way of explanation, it is usual to diffe-  
18 rentiate between English and French language physicians  
19 when discussing advertising literature. As Canadian  
20 companies must print literature in both English and  
21 French, the cost is naturally much higher proportionately  
22 than it is in the U.S., the U.K. or France, where single  
23 languages prevail.

24                   It was further uttered before this Commission  
25 that the majority of statements made in drug advertising  
26 are ambiguous, misleading and with no reference to toxicity.  
27 Outside the realm of opinion, if any credence is being  
28 given to this particular testimony by the Commission, then  
29 we offer this suggestion: That this Commission ask two or  
30 three qualified, knowledgeable and completely disinterested



1 medical practitioners to study all promotional literature  
2 issued by our companies during the past year, and corre-  
3 late this information, showing where the copy would be  
4 ambiguous to a normally knowledgeable practitioner,  
5 deliberately misleading in claims, and containing no  
6 reference to contraindication or toxicity where such would  
7 be normally required by an experienced practitioner. If  
8 we are to be indicted, then we would prefer to be indicted  
9 by fact and not superficial claim.

10           Furthermore, it was inferred "that in 95%  
11 of cases absolutely no information is available on the  
12 cost of the drug to the patient". Dr. Nathan Shecter  
13 said in Ottawa before this Commission that detailmen  
14 will often quote the price. Any detailman will tell you  
15 that one of the questions asked by a doctor on the intro-  
16 duction of a new product, is how much does that product  
17 cost. Price is not generally included in medical litera-  
18 ture, for the simple reason that this literature goes to  
19 doctors from coast to coast. To do this, the manufacturer  
20 would have to use his suggested list price which might  
21 not be the final price in all areas depending upon  
22 differences in prescription fees, the variances in the  
23 retailers' overhead in different areas, and similar  
24 factors. However, the detailman is quite prepared to  
25 discuss the price of his products with the doctor at any  
26 time.

27           MR. FRAWLEY: Mr. Conder, the quote at the  
28 bottom of page 70, that is a quote from a statement of  
29 whom, please?

30           MR. CONDER: That is a quotation taken out



1 of the transcript from the evidence submitted in Winnipeg.

2 MR. FRAWLEY: Is it Dr. Gemmell again?

3 MR. CONDER: Yes it is.

4 It would be possible for us to give our  
5 views on every statement made before this Commission  
6 during its hearings, but we have merely attempted to  
7 select the more pertinent points which we believe are of  
8 interest to the Commission. The Commission's major task,  
9 of course, will be in the eventual sifting of all the  
10 evidence submitted. If at that time specific questions  
11 concerning advertising and promotion arise, we will be  
12 pleased to submit a supplementary brief, or provide the  
13 answers via mail.

14 THE CHAIRMAN: This would be a good time to  
15 have a break.

16

17 --- Short Recess

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MT/dpw

1 THE CHAIRMAN: Mr. Conder?

2 MR. CONDER: Yes, sir. On the subject of  
3 patents.

4 PATENTS

5 The green book deals extensively with the  
6 subject of patents, and their so-called monopolistic  
7 effect on prices. Broadly speaking, the term "monopoly"  
8 in respect to business has gained a notorious connotation.  
9 But this is not so when it is used in legal references to  
10 patents. The Patent Act is specifically designed to  
11 create monopolistic situations, in that it gives by law a  
12 monopoly to the creator of a new product. In most fields,  
13 this monopoly is for 17 years. But in the field of pharma-  
14 ceuticals, this 17-year legal protection has been virtually  
15 eliminated by the compulsory licensing provision.

16 If anything, Canada's patent laws have been  
17 specifically designed to prevent a pharmaceutical manufac-  
18 turer from attaining the same benefits from his research  
19 endeavours as do companies in other industries. There is,  
20 in effect, a discrimination against medical research  
21 compared to other forms of research, which is particularly  
22 significant in view of the important role of product  
23 development within the industry. This discrimination is  
24 based on the assumption that a curtailment of patents  
25 rights in medical research is in the best public interest.

26 It has been suggested, albeit not in the  
27 green book, that Canada should do away completely with  
28 patents to promote the greater importation of medication  
29 from abroad. If this were done in the United States as  
30 well, there is no doubt that North America would, in





1 essence, be trading price for future discovery. Conse-  
2 quently, there must be at least a modicum of incentive in  
3 the law, for both wholly-owned Canadian manufacturers and  
4 subsidiaries of foreign corporations, to further the  
5 interests of research and its important bearing on future  
6 discovery.

7                   Recognizing this principle and the fact  
8 that it is also important to encourage manufacturing in  
9 Canada, the government has instituted the compulsory  
10 licensing provision which serves as a compromise between  
11 complete patent protection and no patent protection.

12                   With this background, the green book states  
13 that prices of certain drugs are affected by the control  
14 exercised through patents, and that the compulsory licen-  
15 sing provision has been ineffectual to combat this situa-  
16 tion "and the clear intent of the Act has been frustrated".  
17 This conclusion appears on page 257, directly under the  
18 paragraph which states in part that "certain conditions  
19 have given rise to a great deal of controversy, and judge-  
20 ments about them will necessarily involve opinion".

21                   We suggest that the conclusions concerning  
22 patents are based on opinion and not fact. Furthermore,  
23 it is significant that of all the representations concer-  
24 ning patents made to date before this Commission, only  
25 one person, the Commissioner of Patents, was qualified to  
26 speak on the subject. The remainder largely used the  
27 wording of the green book as their sources of information.

28                   Firstly, in respect to prices, the  
29 Commissioner of Patents apparently does not agree that  
30 patents have a major bearing on prices. In his testimony,



1 Mr. J.W.T. Michel stated that the patent system, if it is  
2 a factor in the price of drugs, "it certainly is not the  
3 main factor".

4 It is an economic fact that any company  
5 introducing a drug to the market must base its price on  
6 those of other products already on the market which  
7 compete with it in the therapeutic class concerned.  
8 There is virtually no specialty drug on the market today  
9 whose therapeutic effect cannot be approximated by some  
10 other drug.

11 THE CHAIRMAN: What you mean by the first  
12 sentence, I suppose, Mr. Conder, any company introducing  
13 a product to the market cannot fix a price that is much  
14 higher than products already on the market which compete  
15 with them?

16 MR. CONDER: Yes, sir. The new product  
17 must be prepared to compete with others.

18 THE CHAIRMAN: Must base its price - it  
19 can't set a price which is much higher?

20 MR. CONDER: That is correct.

21 Regardless of how strong the patent on a  
22 new drug, it does not by any stretch of the imagination  
23 give that company a free hand to inflate price beyond  
24 reason. If that were done, there is no doubt that detail-  
25 men representing competitors' products would bring this  
26 point to the attention of the medical profession.

27 If the process involved in making the product  
28 is too costly in relation to that of its competitors, then  
29 the company must find a more economical means to bring down  
30 costs so that the end price will not be too far out of line.



1 This factor can mean the difference between a large-volume  
2 or low-volume product, regardless of the patent.

3 MR. WHITELEY: What do you consider in a  
4 situation where a new product is in effect a radically  
5 new approach to the condition that is going to be treated?

6 MR. CONDER: Well then, if that were the  
7 case, then this would be an entirely new form of medica-  
8 tion which possibly, if it is far superior in every respect,  
9 if, for example, it is competing with other products in  
10 the same therapeutic class, and these other products have  
11 a high degree of toxicity in certain areas, or major  
12 side-effects, and even so it takes a long time for the  
13 treatment and use of these other products in that form of  
14 treatment, if this new product shortens the length of  
15 treatment down considerably, and does away completely with  
16 all the side-effects and other problem areas which exist  
17 in these other products, then certainly this would be a  
18 far superior form of medication as such.

19 If that is the case then the companies would  
20 attempt to establish a price which would be competitive  
21 with other products because if it could do that it could  
22 most certainly take over the market from all the other  
23 products eventually over a period of time.

24 MR. WHITELEY: Take the situation where the  
25 broad spectrum antibiotic as compared with the narrower  
26 line, what relationship would there be there in terms of  
27 price?

28 MR. CONDER: Relationships there in terms  
29 of price might be based on a considerable number of factors.  
30 It could be based, for example, on the cost factor, and it



1 might conceivably cost - it must cost more, rather, to  
2 manufacture a broad spectrum antibiotic than one of the  
3 narrower antibiotics. In dealing with the broad spectrum  
4 antibiotic you are introducing something brand new to the  
5 market at that time.

6 MR. WHITELEY: This was the point I origi-  
7 nally raised.

8 MR. CONDER: Whereas the narrower ones will  
9 have been on the market for some time and used widely,  
10 and of course a price could be much lower.

11 THE CHAIRMAN: We had one of the best  
12 examples I think in tetracycline or Aureomycin.

13 MR. CONDER: Yes, that is correct.

14 THE CHAIRMAN: Which was in a position of  
15 practical monopoly for about a year, and that was a drug  
16 which apparently had very wide acceptance, and was  
17 considered to be much better than anything else on the  
18 market at the time. True, penicillin was there, but  
19 Aureomycin or tetracycline was considered to be much  
20 more effective, and therefore it had practically a mono-  
21 poly.

22 I think the sort of question in Mr. White-  
23 ley's mind is where you have that kind of situation is  
24 there any compelling price limitation arising from a compe-  
25 titive drug?

26 MR. CONDER: I think they must always  
27 consider a price competition from the other product on  
28 the market regardless of how effective this new medication  
29 may be, because it does take time for the medical profes-  
30 sion to come around to prescribing a new drug and dropping





1 all the old drugs which it has been using for many years.  
2 If the company inflates the price too high or it is too  
3 far out of reason, it will take that much longer before  
4 it can get such a complete acceptance of the new product.

5 THE CHAIRMAN: On a question of that kind,  
6 it seems to me you have something that is completely new,  
7 as Mr. Whiteley was suggesting, and there isn't any price  
8 competition from other products that you can pin down and  
9 say "Now, if I charge another 50 cents a 100 for these  
10 tablets I won't be able to sell because this other drug  
11 is in competition". Competition is not close enough.

12 MR. CONDER: That is true.

13 THE CHAIRMAN: That you can see any immediate  
14 reaction of that kind. If your new product is so much  
15 better than what is already on the market you may be able  
16 to charge a considerably higher price and still do most  
17 of the business.

18 MR. CONDER: On this, sir, would you be  
19 interested in a brief review of a list of some of the  
20 factors considered when a company does produce or market  
21 a new pharmaceutical product?

22 THE CHAIRMAN: It wouldn't do any harm. In  
23 some circumstances considerations are different than  
24 others. As far as prices, not on the same level as if  
25 there are other competing products ---

26 MR. HANSARD: I don't like to intervene with  
27 somebody else's witness, but I have had a certain amount  
28 of experience, not recently, with patents, and of course  
29 the thing that overhangs the whole situation is the compul-  
30 sory licence. The minute somebody comes out with something



1 and tries to charge more than it should, than should be  
2 charged for it, that attracts somebody else, and a compul-  
3 sory licence comes into it, and that provision for compul-  
4 sory licence is there. One of the reasons that there  
5 have been relatively few compulsory licences - but there  
6 have been a good many - one of the reasons why that is so  
7 is because responsible people who have been bringing out  
8 these things have not taken advantage of the situation and  
9 they have been supplying the market at prices which people  
10 in the industry know what it costs to make these things,  
11 prices which are related to these costs. Therefore if  
12 someone is making more money than he should, he will have  
13 compulsory applications, compulsory licences on his tail  
14 right away, and the fact that that has not happened is an  
15 indication it has not been done.

16 THE CHAIRMAN: I rather suggest the compul-  
17 sory licence may have some public beneficial result.

18 MR. HANSARD: Nobody suggests that may not  
19 be so.

20 THE CHAIRMAN: I am not suggesting you are  
21 not, but it is from a somewhat different angle than what  
22 is in the brief.

23 MR. HANSARD: That is right.

24 MR. HUME: I think the simple answer, Mr.  
25 Chairman, to Mr. Whiteley's inquiry is a brand new product,  
26 a monopoly does give an advantage, and that is what the  
27 Patent Act intends. That is what patents do. If I invent  
28 a new kind of cigarette lighter, for 17 years nobody else  
29 can reproduce it. I can charge anything I can get for it,  
30 and when my patent runs out - a Ronson lighter instead of



1 being \$4.50 is 85 cents.

2 THE CHAIRMAN: There are other cigarette  
3 lighters on the market which are in competition with it.

4 MR. HUME: Yes.

5 THE CHAIRMAN: But what Mr. Whiteley is  
6 suggesting is the kind of case when there is not any drug  
7 which is really in competition.

8 MR. HUME: Then Mr. Hansard's remark, and  
9 I would say in answer to Mr. Whiteley, one must bear in  
10 mind a patent is not on the product, but on the process.  
11 I think Mr. Thompson's evidence was quite clear even  
12 though they bring out a new thing, somebody else brings  
13 out a synthetic by another process. Besides, if a drug  
14 is imported, it is very difficult to prove that the manu-  
15 facturer in the country of origin used your process for a  
16 trial. According to Mr. Thompson's evidence, in one drug  
17 where you indicate a virtual monopoly for a period of a  
18 year, it was not very long before he got caught up in a  
19 competitive situation.

20 I think all those factors bear in mind in  
21 what is really a hypothetical situation - but it is an  
2 22 important one - so does not work here. This is not so of  
23 the United States of course.

24 MR. CONDER: The green book further submits  
25 the opinion that U.S. patent law determines the situation  
26 in Canada, and because U.S. firms are so active in Canada  
27 their products are the best known and hence the most  
28 widely used. We doubt whether non-U.S. companies would  
29 agree with this statement.

30 What is apparent, however, is that the



1 United States "only gets 15 per cent of foreign (patent)  
2 applications that come through", according to the Commis-  
3 sioner of Patents. This would indicate that if subsidia-  
4 ries of U.S. companies have a proportionately greater  
5 share of this market, it is not because of their patent  
6 position. It is more likely that the 85 per cent of non-  
7 U.S. patents would exert a greater influence on the  
8 Canadian market.

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H/MR/hm

1 MR. WHITELEY: Mr. Conder, I am not sure  
2 whether the patent is accurately reported in this statement.  
3 I haven't had an opportunity to look up the figures but  
4 my recollection is that this 15% is not an accurate figure.  
5 Have you checked that?

6 MR. CONDER: I looked it up myself sir and  
7 unless there is -- I will be glad to do a check on that  
8 again at Noon.

9 THE CHAIRMAN: The annual reports under the  
10 Patent Act ---

11 MR. CONDER : This statement was taken from  
12 the transcript.

13 THE CHAIRMAN: Oh, I realize that. I am  
14 wondering whether it is accurate reporting or whether there  
15 is some slip up in this figure of 15%.

16 MR. CONDER: I honestly wouldn't know about  
17 this.

18 MR. HUME: It was taken on its face value.  
19 Has Mr. MacLeod a copy of the transcript for July 5th?

20 THE CHAIRMAN: It isn't a matter of the  
21 transcript -- it isn't whether the transcript is a true  
22 reporting of what the Commissioner of Patents said but we  
23 have been told that in no other place in the world has the  
24 development of drugs proceeded at the pace that has taken  
25 place in the United States and Canada and taking the United  
26 States one rather expects more than 15% of patents under  
27 those circumstances.

28 MR. WHITELEY: My recollection was that the  
29 figure is around 85%. It will be possible to verify what  
30 the actual figure is. I happen to know that in the green



1 book there are a list of patents here from pages 34 to 37.  
2 I ran through that list hurriedly and I came up with these  
3 totals: Countries in which the patentee resides you get  
4 a total of 328 for the United States; 89 for foreign  
5 countries other than the United States and 9 for Canada.  
6 Those figures more or less correspond with the impression  
7 I had as to the relative importance of the different  
8 countries.

9 MR. CONDER: Yes sir, but we must also  
10 realize that this covers I believe primarily ataractics and  
11 antibiotics.

12 MR. WHITELEY: They are a selective list,  
13 that is true.

14 MR. CONDER: These two products represent  
15 only about 16% of the total number of pharmaceuticals sold  
16 in Canada. Furthermore, these products ---

17 THE CHAIRMAN: Under patent?

18 MR. CONDER: I don't know about under patent.  
19 I am speaking of the total number of drugs. There is  
20 another point on this too sir that most of the major  
21 discoveries, particularly in this area in the antibiotic  
22 and ataractic area have resulted from the United States  
23 so it stands to reason that these products would be  
24 primarily United States products. '

25 THE CHAIRMAN: Oh I realize that they may  
26 not be representative.

27 MR. WHITELEY: That figure of 15% strikes  
28 me as not an accurate figure.

29 MR. CONDER: It was taken at its face value  
30 from the transcript at that time Mr. Whiteley.



1 THE CHAIRMAN: We will try to check.

2 MR. MacLEOD: I have the evidence of Mr.  
3 Michel here. This is in respect of applications received  
4 yearly in connection with all products of every description.

5 THE CHAIRMAN: Not just drugs?

6 MR. MacLEOD: Not just drugs, no.

7 THE CHAIRMAN: It is not of any particular  
8 interest.

9 MR. WHITELEY: Even so I don't think -- at  
10 least my recollection is that is not the proportion.

11 THE CHAIRMAN: Even if it were correct for  
12 all products, it might have very little relation to drugs.

13 "MR. MACLEOD: Mr. Michel, can you give  
14 us any estimate of the percentage of the patents which  
15 are patented in Canada which are obtained by Canadians?

16 THE CHAIRMAN: In the field of drugs?

17 MR. MICHEL: Less than six per cent,  
18 5.9 in the last year.

19 MR. MACLEOD: Is that patents generally?

20 MR. MICHEL: Yes.

21 MR. MACLEOD: What would the situation  
22 be with respect to patents on drugs?

23 MR. MICHEL: Well, frankly, sir, I  
24 think no record has ever been kept on that. You say  
25 patents of Canadian origin?

26 MR. MACLEOD: Yes.

27 MR. MICHEL: I would say the  
28 percentage would be lower.

29 MR. MACLEOD: Would be lower. It is  
30 six per cent and in the case of drugs you think it



1 might be lower.

2 MR. MICHEL: Definitely, I would say  
3 definitely lower, definitely lower. Of course, here  
4 I must explain, don't get scared by this figure of six  
5 per cent of Canadian inventions, don't go along  
6 and think our Canadian people are dumb. I have  
7 to explain that - I work for the Secretary of State,  
8 and we change Ministers every year and I have to  
9 explain to him. It is not every year, but quite  
10 often.

11 MR. FRAWLEY: Every time there is  
12 a new minister.

13 MR. MICHEL: The explanation seems  
14 to me - we have made a survey in the Patent Office  
15 of this, and foreign inventors, foreign companies  
16 that apply here - we follow the trend and we look,  
17 we look for these inventions, where they made  
18 applications. We will find most inevitably the  
19 American, Frenchmen, Englishmen, German, Italian -  
20 they will file at home and the next filing is Canada.  
21 The British will only file in the States after  
22 filing in Canada. The French are doing the same  
23 thing. It is a coincidence.

24 The explanation, whether I am right  
25 or wrong about economics, we are a young and obviously  
26 progressing country getting industrialized. I think  
27 most of these people, most of the manufacturers  
28 know that we have all kinds of natural resources.  
29 I think they have great confidence in the future of  
30 Canada. I think that is the explanation. After all,





1 if you go to some other countries which are not  
2 very, very big, like us, you will find a very great  
3 percentage come from - if these countries are  
4 industrialized, a very great number of applications  
5 come from foreign countries. The United States  
6 only gets 15 per cent of foreign applications that  
7 come through. In Great Britain I think in the  
8 order of 40 per cent are foreign.

9 MR. MACLEOD: Forty per cent?"  
10 That would mean that in the United States foreign applica-  
11 tions are only 15%. In Great Britain in the order of  
12 40 per cent.

13 MR. HUME: So that what he is saying is  
14 that foreign applications after they file in Canada then  
15 the United States only get 15% of the ones filed in Canada  
16 first? I am having some difficulty -- I read that, and  
17 I am sorry we have misinterpreted it.

18 THE CHAIRMAN: It apparently does not mean of the  
19 patent applications that come into Canada only 15% originated  
20 in the United States. I don't see any connection in that  
21 statement -- if that is the source from which it comes.

22 MR. HUME: That is the exact quotation, so  
23 we have misinterpreted that.

24 MR. CONDER: In the light of Mr. Whiteley's  
25 remarks, Mr. Chairman, the Commission might consider asking  
26 Mr. Michel for a qualification of this particular area.

27 MR. WHITELEY: I think the annual report of the  
28 Patent Commissioner shows the origin of patent applications.  
29 I think the summary is published each year in the Canada  
30 Year Book.



1 THE CHAIRMAN: This doesn't seem to deal  
2 with the actual point we were making. As I read the  
3 paragraph, the United States only gets 15% of foreign  
4 applications that come through. In Great Britain they  
5 are in the order of 40%.

6 MR. HUME: It is a little hard to interpret  
7 the language.

8 THE CHAIRMAN: Perhaps it doesn't mean  
9 exactly what you think it means.

10 MR. HUME: The next page of the statement,  
11 of course, relies upon the interpretation which we have  
12 mistakenly taken from his evidence so that perhaps it could  
13 be put into the record with the qualification that we have  
14 now been discussing.

15 MR. WHITELEY: I am wondering what your  
16 point would be if the point is 85%

17 MR. HUME: Well, there is no point at all.  
18 We are not making any point at all if we start off on a  
19 wrong premise. We can jump the next page if you want to  
20 save a little time because our premise is based upon our  
21 understanding of the statement we have made here, which  
22 is an incorrect statement.

23 MR. CONDER: Mr. Hume, I would suggest that  
24 we retain page 74. That statement stands by itself.

25 MR. HUME: All right, fine.

26 MR. CONDER: From an arms length viewpoint,  
27 there are two criticisms of our industry which cannot be  
28 reconciled. One is that patents result in a limitation on  
29 the number of products placed on the market. The other is  
30 that the industry is placing too many products on the market.



1 In one case we are being condemned for preventing others  
2 from entering the market with similar competing products  
3 while, on the other hand, it is being stated that there are  
4 now too many competing products being introduced.

5 Obviously, both assumptions cannot be  
6 correct, and this point is offered as further evidence that  
7 pharmaceutical manufacturing in Canada has been unjustly  
8 criticized by uninformed opinion rather than substantiated  
9 fact. We agree that there is a large number of products  
10 on the market in any therapeutic class, but this gives  
11 the medical practitioner a choice based on a competitive  
12 factor which is most certainly in the best public interest.  
13 There has been some regret expressed before this Commission  
14 that not enough companies are applying for compulsory  
15 licensing through the Commissioner of Patents. However,  
16 the number of applications approved at Ottawa alone cannot  
17 be used as satisfactory evidence that the compulsory  
18 licensing provision is not working in this country.

19 Section 41 (3) is working according to the  
20 intent and expectations of its legislators. As was pointed  
21 out by the Royal Commission on Patents in its 1960 report,  
22 "It is generally considered that the mere existence of such  
23 provisions leads to voluntary licensing which otherwise would  
24 not take place." In order to bear out this point, we  
25 surveyed our member companies to determine the number of  
26 licenses which have been granted voluntarily.

27 The 39 companies which replied to this survey  
28 reported they had voluntarily licensed 17 products to 32  
29 competitors within the past six years. The breakdown is  
30 as follows:



1                    Could we have that table taken as read  
2 Mr. Chairman?

3                    MR. CARIGNAN: Mr. Conder are you in a  
4 position to tell us in how many of these 32 cases the  
5 licensee is a Canadian subsidiary of a foreign firm and  
6 the licensor the foreign parent company?

7                    MR. CONDER: I am afraid I do not have that  
8 information with me. I frankly do not believe that a record  
9 of that was kept at that time. I do recall sir comments  
10 that were made on some of these questionnaires, however,  
11 that the companies receiving the licences were not  
12 necessarily all Canadian companies. There were others  
13 involved as well.

14                   THE CHAIRMAN: These are Canadian companies  
15 granting ---

16                   MR. CONDER: These are Canadian companies,  
17 I mean wholly-owned Canadian companies.

18                   MR. HUME: To competitors, not to sub-  
19 sidiaries.

20                   MR. CONDER: To competitors.

21                   MR. HUME: The number indicates 32 competitors  
22 so it would not be Mr. Carignan, I don't think -- what you  
23 have in mind, Mr. Thompson indicated, for example, that  
24 Canadian Cyanamid was a licensee under American Cyanamid.  
25 This survey was a survey of Canadian companies, be they  
26 wholly-owned Canadian or subsidiaries and licences they gave  
27 to competitors.

28                   MR. HANSARD: As I understand it, Mr. Chairman,  
29 there is no necessity, in the case of a relationship between  
30 a parent and subsidiary. That would be a very rare thing.





1 Be no necessity for licence at all.

2 MR. CONDER: Certainly these figures do not  
3 cover that.

4 MR. CARIGNAN: We had a case yesterday.

5 MR. HANSARD: Did we? I am sorry, I missed  
6 that.

7 MR. CARIGNAN: Cyanamid of Canada said that  
8 they were a licensee of American Cyanamid.

9 MR. CONDER: This doesn't cover this type  
10 of thing.

11 MR. CARIGNAN: It wouldn't be included in  
12 these?

13 MR. CONDER: No, it wouldn't. These are  
14 all competitors, or other companies.

15 MR. WHITELEY: How many companies reportedly  
16 granted licences?

17 MR. CONDER: I do not have the exact break-  
18 down on that. At the most I presume it would be 17, Mr.  
19 Whiteley.

20 MR. WHITELEY: Well I notice that of the 17  
21 there are 12 in two groups: The local anaesthetics and  
22 sulfa group. I was wondering in either of those cases  
23 did the one company grant a number of licences?

24 MR. CONDER: No, there are quite a few  
25 companies. It would be closer, definitely closer to the  
26 17 than the other way around.

27 MR. WHITELEY: In those two instances?

28 MR. CONDER: I am afraid I do not have that  
29 information.

30 MR. FRAWLEY: Do you have the data there,



1 Mr. Conder, that would enable you to say the name of the  
2 company, where you have one company volunteered licences  
3 in any of these instances? I notice that in 1954 Cortico-  
4 Steroid was licensed to one company. Do you know which  
5 company that was?

6 MR. CONDER: I do not have that information  
7 available Mr. Frawley. It was discarded after we took  
8 this material from the tabulation forms.

9 THE CHAIRMAN: We don't really know from this  
10 then how many companies did grant licences because in one  
11 instance there are eight licences for local anaesthetic.  
12 We don't know whether they were all granted by one company  
13 or other companies. Four licences granted in the sulfa-  
14 streptomycin combination. We don't know whether they were  
15 all granted by one company or more than one so we don't  
16 really know how many actually granted licences. We know  
17 out of the 39 a number of them granted licences for 17  
18 products?

19 MR. CONDER: That is correct.  
20 -  
21  
22 -  
23  
24  
25  
26 -  
27  
28  
29  
30 -



ANGUS, STONEHOUSE & CO. LTD.  
TORONTO, ONTARIO

Conder

1990

I/PB/hm	1	TYPE OF PRODUCT	DATE GRANTED	NO. COMPANIES VOL. LICENSED
	2	Antihistaminic	1960	1
	3	Local Anaesthetic	1955	8
	4	Ataractic	-	2
	5	Antibiotic Fungicide	1960	3
	6	Synthetic Antimicrobial	1959	1
	7	Oral Antidiabetic	1957	1
	8	Hormone Substance	1954	2
	9	Antihypertensive tranquilizer	1956	1
	10	Antiseptic	1954	1
	11	Antibiotic	1957	2
	12	Sali-Diuretic & Antihypertensive	1959	1
	13	Cortico-Steroid	1954	1
	14	Injectable	1956	1
	15	"Various"	1957	1
	16	Enema	1959	1
	17	Enema	1959	1
	18	Sulfa-Streptomycin Comb.	1956-59	4

19 MR. CONDER: I might add the paragraph  
20 following this, if I may read it, it clarifies that.

21 Some of these 39 companies refused to  
22 divulge this information on the grounds that it is confi-  
23 dential. One major company states, "we do not own any  
24 patents". Others said that they have taken voluntary  
25 licenses from competitors, but have not granted licenses  
26 themselves. One of these, a wholly-owned Canadian firm,  
27 reported receiving eight voluntary licenses from eight  
28 different companies during 1955-60, six of which are not  
29 included in the above list.

30



1 From the owner's standpoint, it is not  
2 always worth the expense involved to contest an application  
3 for a patent at Ottawa. The applicant usually applies to the  
4 owner first and where the applicant is manufacturing in  
5 Canada and has the facilities to make the product, the  
6 owner will often attempt to get the best deal possible from  
7 the applicant without resorting to legal action.

8 MR. HANSARD: Might I interrupt at the  
9 beginning of the paragraph "to contest an application for  
10 a patent at Ottawa", should that not be an application for  
11 a compulsory licence?

12 MR. HUME: Yes, for a compulsory licence.

13 MR. CONDER: What point is this?

14 MR. HANSARD: It appears on the second line  
15 of this paragraph.

16 MR. HUME: You are concerned there with the  
17 problem of obtaining licence and not a patent.

18 MR. CONDER: I am sorry, that is definitely  
19 an error.

20 THE CHAIRMAN: It should be a licence instead  
21 of patent?

22 MR. CONDER: A licence, yes sir.

23 MR. HUME: Probably the word licence before  
24 the word patent is left out.

25 MR. FRAWLEY: For a patent licence, you mean?

26 MR. CONDER: May we change that, Mr. Chairman,  
27 to patent licence?

28 THE CHAIRMAN: Change it to compulsory patent  
29 licence, the application isn't a voluntary one.

30 MR. CONDER: Voluntary patent licence.





1 This is the rule rather than the exception.  
2 The results of a voluntary license are not generally known  
3 at Ottawa for, as Mr. Michel has pointed out, it is not  
4 essential that a voluntary license be registered with  
5 the Patent Office.

6 It has been held, and rightly so, that a  
7 compulsory license should not be granted to an importer.  
8 If this were done, there would be no incentive whatever  
9 to establishing manufacturing facilities in this country.  
10 Yet a number of importers are actually bringing into this  
11 country patented products for which they hold no licenses,  
12 in contravention of the Patent Act, and in some cases  
13 have been actually selling these products to Federal Govern-  
14 ment purchasing departments.

15 THE CHAIRMAN: To get back to the previous  
16 paragraph, Mr. Conder, as I gather from this paragraph  
17 the existence of the compulsory licence provision in our  
18 law results in a number of voluntary licences being  
19 given which otherwise might not be given?

20 MR. CONDER: To answer that question myself,  
21 Mr. Chairman, it would be pure conjecture.

22 THE CHAIRMAN: The paragraph indicates that  
23 by saying "It is not always worth the expense involved to  
24 contest an application for a patent at Ottawa", indicating  
25 the expense of contesting a compulsory licence is not  
26 worthwhile, so they make a deal. It would seem to indicate  
27 they probably wouldn't get voluntary licences if it wasn't  
28 for the compulsory licences.

29 MR. CONDER: Yes.

30 MR. CARIGNAN: At page 76 in the second



1 paragraph you imply, I think, that patent rights are  
2 currently infringed by importers. It has been said. It  
3 is very difficult to verify. That is a possibility, but  
4 it is very difficult to verify.

5 MR. HUME: I could perhaps assist the  
6 Commission, Mr. Carignan. There are currently some four,  
7 five or six cases before the Exchequer Court on this  
8 point, matters sub judice, haven't yet been tried. The  
9 allegations of the plaintiffs are goods are being imported  
10 in contravention of the Patent Act. This information, I  
11 think, is available from the Exchequer Court office. I  
12 don't have it here. I know these are, in fact, on the  
13 list and are about to be or are ready - some, I think,  
14 may have been disposed of. I think one has been.

15 THE CHAIRMAN: By the time they are disposed  
16 of we may be better informed how difficult it is.

17 MR. FRAWLEY: Mr. Conder, would you mind  
18 clarifying is a compulsory licence granted to an importer,  
19 the person who simply has a warehouse and is not manufac-  
20 turing? I haven't the Section.

21 MR. CONDER: I say compulsory licences should  
22 not be for importers.

23 MR. FRAWLEY: There is no provision - my  
24 question is does the Statute now provide it may be issued  
25 to such a person?

26 MR. CONDER: No sir, I believe it is a  
27 matter of finding by the Commissioner of Patents in a  
28 decision laid down in Ottawa.

29 MR. HANSARD: But the licence must be to  
30 work the patent in Canada. It is not a licence to import



1 MR. HUME: Licence to manufacture.

2 MR. FRAWLEY: That is what I thought. If it  
3 is a compulsory licence to manufacture how could it be  
4 given to a man who is just an importer, just warehousing?

5 MR. CONDER: Apparently some people felt  
6 it should be done. An action was taken in that case and  
7 produced this result.

8 MR. FRAWLEY: It is Statute 6-43-1,  
9 the proper interpretation.

10 MR. HUME: I could assist, I know application  
11 has been made to the Commissioner of Patents. In one  
12 case I know the application was received and the applicant  
13 was a man who is characterized in this paragraph as an  
14 importer. The reasons for the refusal are a matter of  
15 record. I don't have the judgment from the Commissioner.  
16 It may be he didn't have proper manufacturing facilities.  
17 He applied and there was a contest and there was a hearing.  
18 Is my statement correct?

19 MR. CONDER: I believe that is correct, Mr.  
20 Hume.

21 From the applicant's standpoint, it is  
22 often the economics of the situation which determine  
23 whether a license is interesting. For example, it would  
24 not be profitable for a company to demand a license for  
25 a low-volume product on which the owner is breaking even  
26 or operating at a loss. Nor would it be practical for a  
27 company to call for a license on a biological when it does  
28 not have the facilities with which to make biologicals.

29 By the same token, a company is not going  
30 to demand a license for a product where it already has a



1 competing product in the same therapeutic class. These  
2 are but a few of the reasons why licenses are not always  
3 requested, and it is incorrect to state that our licensing  
4 provision is not working because competitors are not  
5 demanding compulsory licenses from each other in profusion.

6                   There are a great number of non-U.S. firms  
7 in this industry and if they felt it economically desirable  
8 to demand either a compulsory or voluntary license there  
9 is nothing to prevent them from doing so. And as we indi-  
10 cated earlier, this is being done continually.

11                   The argument that it takes too long to  
12 obtain a compulsory license to make it worthwhile to the  
13 applicant, is relative. Mr. Michel has stated that an  
14 application from a competent company and patent agent can  
15 be disposed of within a year. That in itself is a short  
16 time in respect to the years often required by the owner  
17 to produce the process for the original product. It often  
18 takes that long to prepare the new drug submission alone,  
19 which the originator must submit to the Food and Drug  
20 Directorate.

21                   Finally, it would be to the decided advan-  
22 tage of importers to do away with patents on pharmaceuticals  
23 in Canada. For one thing, it might conceivably save them  
24 the expenses of contesting possible future patent infringe-  
25 ment cases. But this would not be in the best interests  
26 of Canada or its people. A strong domestic manufacturing  
27 industry is vital to the future of our nation, both as a  
28 means of retaining national productivity and employment,  
29 and as a bulwark for the future medical needs of Canadians.

30                   In the words of Mr. J.W.T. Michel,





1 Commissioner of Patents for Canada:

2 "I am wondering if too drastic a treatment  
3 of the patent system would not harm the modest, but bona  
4 fide, efforts of those doing research in Canada more than  
5 the... prices of drugs which might be attributed to the  
6 patent system. After all, our pharmaceutical manufacturing  
7 industry is still quite small, but so were many of our  
8 industries not so many years ago".

9 CONCLUSION

10 As Dr. Brian Dixon points out in Appendix C,  
11 pharmaceutical manufacturing in Canada is a highly compe-  
12 titive industry, and this "competitive activity is  
13 generally directed in a manner which is socially desirable".  
14 For the reasons outlined in this representation, any inter-  
15 ference with the industry's present methods of marketing  
16 pharmaceuticals could have an adverse effect on competition  
17 in that it would curtail the competitive activities of the  
18 large companies and retard continued growth of the small  
19 companies.

20 It is obvious that no monopoly exists in  
21 Canada's pharmaceutical manufacturing industry, for mono-  
22 poly is resistant to change and change has long been an  
23 inherent attribute of this industry. The so-called mono-  
24 poly through patents is questionable, in that the compul-  
25 sory licensing provision of the Patent Act has virtually  
26 eliminated the right normally given to inventors in other  
27 fields of endeavour. And, as we have indicated, the com-  
28 pulsory licensing provision is working according to the  
29 intent of its legislators.

30 Pharmaceutical manufacturing operates much



1 the same as other industries in our competitive free enter-  
2 prise economy. The breakdown of this industry's sales  
3 dollar is not much different from the national average for  
4 all manufacturing industries. In addition, the majority  
5 of drugs sold in Canada are made here, although most raw  
6 materials are imported.

7                   Profits are not out of line with the average  
8 for all manufacturing in Canada, and prices to retailers  
9 compare favourably with those in most other high economy  
10 countries. The average Canadian can well afford to pur-  
11 chase pharmaceuticals, for retail prices are within the  
12 average worker's purchasing ability. The problem of drug  
13 purchases by the small percentage of social or economic  
14 indigents in this country is a matter of welfare rather  
15 than prices.

16                   Whether elimination of the 11 per cent sales  
17 tax is necessary in light of the reasonableness of price  
18 is, naturally, a matter for the government to determine.  
19 However, it is evident that considerably more savings can  
20 be realized by eliminating the sales tax than by curtailing  
21 any other single segment of the present drug economy.  
22 Elimination of this tax would result in savings of millions  
23 of dollars annually to the consumer of drugs.

24                   Much unfounded criticism has been levelled  
25 at this industry in recent years, and this resulted in  
26 demands for an investigation of our industry. The Federal  
27 Government has now met these demands through the facilities  
28 of this Commission.

29                   It is understood that the green book is  
30 merely a compilation of material to form the basis for a



1 study of the industry. Witnesses were expected to submit  
2 further evidence in support of or contrary to this compila-  
3 tion of material. Significantly, many of the witnesses  
4 who have appeared before this Commission to date have used  
5 the green book as their sole source of evidence.

6           Aside from the expert witnesses, the majo-  
7 rity of whose testimony has not been unfavourable to our  
8 industry, little evidence has been introduced to bear out  
9 the misconceptions about pharmaceutical manufacturing  
10 which have become prevalent in recent years. In fact,  
11 most of the gross exaggerations submitted by witnesses  
12 before this Commission have not been founded on fact or  
13 supporting evidence.

14           From the small number of witnesses which  
15 have appeared before this national inquiry, it is evident  
16 that there is insufficient evidence for the derogatory  
17 claims which have been placed on our collective doorstep.  
18 From our standpoint, this was not unexpected, for our  
19 industry has indeed been operating in the best public  
20 interest.

21           It is our hope that this public inquiry will  
22 help to clear up many of the misunderstandings concerning  
23 pharmaceutical manufacturing in Canada. The answer will,  
24 of course, be found in the final report of this Commission.  
25 Consequently, we have but one request: That the final  
26 report of this Commission include information favourable  
27 to our industry which is warranted by the evidence submit-  
28 ted.

29           This request is not as unusual as it may  
30 appear on the surface. The publication of the green book



1 and subsequent statements made by certain witnesses before  
2 this Commission have resulted in considerable derogatory  
3 publicity in the lay press. While much of this was not  
4 founded on fact, it has nevertheless become public record.  
5 If the material so publicized is found by this Commission  
6 to be incorrect, then in all fairness the public record  
7 should be corrected. And this can only be done in the  
8 Commission's final report.

9 MR. HUME: Now, Mr. Chairman, the references  
10 which appear in the next two pages, I would like to have  
11 that taken into the record as read.

12 REFERENCES

- 13 1. Globe & Mail, Toronto, June 7, 1945.
- 14 2. Pharmaceutical Manufacturers' Association, Washington,  
15 D.C.
- 16 3. Drug Store Audit, June 1961. International Surveys  
17 Ltd., Montreal.
- 18 4. C.P.M.A. Survey #2, 1960.
- 19 5. Clarkson Gordon & Co., survey #3, 1961.
- 20 6. The Financial Post, August 13, 1960.
- 21 7. C.P.M.A. Survey #5, 1961.
- 22 8. C.P.M.A. Survey #4, 1961.
- 23 9. C.P.M.A. Survey #4, 1961.
- 24 10. C.P.M.A. Survey #4, 1961.
- 25 11. Clarkson Gordon & Co., survey #3, 1961.
- 26 12. Henry Glover & Co., survey #1, 1960.
- 27 13. Clarkson Gordon & Co., survey #3, 1961.
- 28 14. Fuller, H.J.: Retail Costs, Prices and Profits.  
29 Canadian Pharmaceutical Journal, September, 1960.
- 30 15. Prices & Price Indexes, July 1961. Dominion Bureau





- 1 of Statistics, Ottawa.
- 2 16. International Labour Office, Geneva, 1959.
- 3 17. The Problem of Rising Prices, May 1961. Organization
- 4 for European Economic Co-operation, Paris.
- 5 18. Prices & Price Indexes, July 1961. Dominion Bureau
- 6 of Statistics, Ottawa.
- 7 19. Batten, H.M., House of Commons Debates, February 16,
- 8 1961.
- 9 20. Statistical Supplement, International Labour Review,
- 10 July-August, 1961.
- 11 21. C.P.M.A. survey of 14 companies.
- 12 22. Kefauver Subcommittee hearings, Washington, 1960-61.
- 13 23. Howard, F., House of Commons Debates, June 22, 1960.
- 14 24. C.P.M.A. Survey #2, 1960.
- 15 25. Clarkson Gordon & Co., survey #3, 1961.
- 16 26. PMA Report to Committee of Consultants on Federal
- 17 Medicinal Research, U.S. Senate Appropriations
- 18 Committee, Washington.
- 19 27. C.P.M.A. Survey #2, 1960.
- 20 28. C.P.M.A. Annual Statistical Survey for the Year 1959.
- 21 See Appendix D.
- 22 29. Stewart, Newell: C.P.M.A. 1961 Spring General Meeting,
- 23 Ste. Adele-en-haut, P.Q.
- 24 30. Hughes, F.N. and Walker, G.C.: "A Prescription Drug
- 25 Survey", Canadian Pharmaceutical Journal, May 1961.
- 26 31. C.P.M.A. Survey #4, 1961.
- 27 32. U.K. Committee on Cost of Prescribing: Report to
- 28 Ministry of Health, 1959.
- 29 33. Levy, G. and Nelson, E.: Pharmaceutical Formulation
- 30 and Therapeutic Efficacy, Journal of the American



- 1 Medical Association, September 9, 1961.
- 2 34. Lozinski, E.: Physiological Availability of Dicumarol,
- 3 Canadian Medical Association Journal, July 23, 1960.
- 4 35. C.P.M.A. Survey #4, 1961.
- 5 36. Michel, J.W.T., Commissioner of Patents: Restrictive
- 6 Trade Practices Commission, July 5, 1961.
- 7 37. Report on Patents of Invention, Royal Commission on
- 8 Patents, Copyright and Industrial Designs, 1960.
- 9 38. C.P.M.A. Survey #4, 1961.

10 MR. HUME: I should like to deal with the

11 appendices in the following way. Appendix A I should like

12 to call on Mr. Conder to read. Appendix B, the list of

13 doctors, I should like to be taken as read. Appendix C,

14 which is the economic report prepared by Dr. Dixon would

15 be filed as an exhibit with Dr. Dixon, after lunch,

16 making comments on it.

17 Appendix D, being the submission of this

18 Association to the Ontario Government Select Committee to

19 be filed as an exhibit.

20 THE CHAIRMAN: Do you propose to have that

21 discussed at all?

22 MR. HUME: We will file it as an exhibit and

23 be delighted to discuss it. We don't propose to read it,

24 that is all. Perhaps you would prefer to have our submis-

25 sion to the Ontario Select Committee taken into the

26 record as read, but it is some 60-odd pages.

27 THE CHAIRMAN: I was wondering whether

28 there might not be some points in it you would like to

29 refer to that are relevant to this hearing.

30 MR. HUME: I only have one comment which I



1 personally intend to draw attention to due to remarks made  
2 in that connection. I don't know that we have any plans  
3 to discuss it. We would be very delighted to answer any  
4 questions the Commission would like to put to us on that  
5 submission. It is a matter of public record and there  
6 have been two or three days of hearings on it. I think  
7 it would be of some assistance to the Commission if I  
8 filed it as an exhibit. It wouldn't clutter up the  
9 record of this transcript, and yet would be available.

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J/JW/hm

1 This Appendix E I should like to have taken as read.  
2 Appendix F is already before you. Perhaps it ought to be  
3 given an exhibit number. So, in the few minutes available  
4 to us now, may I ask Mr. Conder if he would read Appendix  
5 A.

6 THE CHAIRMAN: One question occurred to us  
7 and I think it would just take a moment to clear it up.  
8 On page 67 you refer to this statement made by newspapers  
9 in Calgary about doctors receiving about \$2,500.00 worth  
10 of samples from drug companies each year and you stated  
11 this figure is too high by about at least \$2,000.00. You  
12 go on to say that 39 firms reported a total of \$285.17 or  
13 an average of \$7.31 per company over the 12-month period.

14 So we will know we are both talking about  
15 the same thing, would this \$285.17 be the cost to the  
16 company, or would that represent what would be a suggested  
17 retail price?

18 MR. CONDER: That would be the cost to the  
19 company.

20 THE CHAIRMAN: I suspect -- we did not know,  
21 but I suspect the other man was talking about what he  
22 regarded as the retail price.

23 MR. HUME: Of course he may not.

24 THE CHAIRMAN: He may not have been.

25 MR. HUME: When he talks about someone  
26 distributing \$2,500.00 worth of samples, it is just as  
27 consistent to argue he is talking about worth to the  
28 distributor as he is talking about worth to the public who  
29 never had a chance to buy them anyway.

30 MR. FRAWLEY: I took the trouble to look up





1 the reference to Mr. Romaine's evidence which appears in  
2 volume 10 at pages 1111 and 1112, and so that it will be  
3 clear, please just let me read a paragraph or two.

4 MR. HUME: Before my friends reads, let me  
5 say Mr. Romaine gave his evidence. He was cross-examined.  
6 It is a matter of record and we do not need to have a  
7 double record. In this case the statement is an accurate  
8 quotation, and if you are going to read Mr. Romaine's  
9 evidence, you must read the cross-examination on that  
10 subject.

11 MR. FRAWLEY: On that subject, I don't  
12 think there was any, but I am only doing it because my  
13 friend was interpreting it. He said that must be on the  
14 retail cost level. Let us read it and see.

15 MR. HUME: It is a matter of record and it  
16 is not a matter of argument between my friend and I.

17 MR. FRAWLEY: There is no argument about it.  
18 Surely it is not fair to have what the witness said on  
19 this interpreted in the record by Mr. Hume.

20 THE CHAIRMAN: We have it on the record.  
21 Perhaps we should not take the time, Mr. Frawley. What Mr.  
22 Hume has been giving is argument.

23 MR. FRAWLEY: I have no brief with this  
24 man from Calgary, but my friend was interpreting it at some  
25 length as to what he meant.

26 THE CHAIRMAN: I think we have to leave it  
27 to the record as to what it means.

28 Would you read Appendix A.

29 MR. FRAWLEY: What did you say about Appendix  
30 E, I did not quite get what you said?



1 MR. HUME: It is to be taken as read with  
2 the Chairman's permission.

3 MR. FRAWLEY: What is Appendix E?

4 MR. HUME: I will read what is printed  
5 there. It is a list of research projects, "Excerpts from  
6 the C.M.A.J.". What is that?

7 MR. CONDER: That is the Canadian Medical  
8 Association Journal.

9 MR. FRAWLEY: "Assistance by the pharma-  
10 ceutical manufacturers", so it is a list of research  
11 projects.

12 MR. CONDER: I will now read Appendix A.

13 THE CANADIAN PHARMACEUTICAL MANUFACTURERS ASSOCIATION  
14 INCORPORATED

15 The Canadian Pharmaceutical Manufacturers  
16 Association was founded in 1914, and was incorporated under  
17 the Dominion Companies' Act in 1959. It represents 56  
18 companies engaged in manufacturing and distributing ethical  
19 pharmaceutical preparations in Canada.

20 Membership in the Association is by company,  
21 and the categories comprise Full, Associate and Affiliate  
22 Members. Full membership consists of companies which  
23 manufacture and distribute under their own names in Canada.  
24 Associate membership consists of companies which do not  
25 as yet manufacture in Canada, but which are subsidiaries  
26 of recognized and reputable corporations. When we intro-  
27 duced this system of membership in 1955, there were several  
28 companies in the Association which might be considered  
29 suppliers to the industry. These companies would not be  
30 eligible today, but we permitted them to retain membership



1 in view of their many years of active participation in  
2 Association affairs. These firms come under the Affiliate  
3 category.

4 Quality Control

5                   The most important single requirement for  
6 membership is proper quality control facilities. Our by-  
7 laws state in part that "...membership is open to firms  
8 which manufacture in Canada, under proper conditions for  
9 control of quality and standards, pharmaceutical prepara-  
10 tions....." In the case of a non-manufacturing subsidiary,  
11 then the parent company must meet this requirement. In  
12 order to determine the company's qualifications in this  
13 respect, 11 of the 21 questions on our membership applica-  
14 tion form deal with quality control. These are:

- 15                   10. State name and qualifications of  
16                   person in charge of control.
- 17                   11. State name and qualifications of person  
18                   authorized to release finished products.
- 19                   12. State number of qualifications of  
20                   chemists in control department.
- 21                   13. Broadly describe control laboratory  
22                   and give approximate floor area.
- 23                   14. List principal equipment in control  
24                   laboratory.
- 25                   15. Check type of laboratory analysis made:  
26                   a. physiological, b. biological, c. chemical,  
27                   d. bacteriological.
- 28                   16. State whether each product batch is  
29                   identified by code through manufacture and  
30                   distribution.



17. State extent to which raw materials are analyzed to assure their integrity.

18. State extent to which finished products are analyzed to assure their integrity.

19. State extent to which products requiring biological tests are so examined, and state reasons for any omission of such tests.

20. Name those who do outside control work for you and describe it.

When these questions have been answered and submitted by the applicant, the form is then turned over to our Membership Committee for processing. Two Directors are then required to visit the premises of the applicant to determine whether the statements made are correct. If the applicant does not meet these requirements, then he is not eligible for election to membership.

#### Ehtical Responsibility

Applicants for membership are also required to sign an agreement that they will abide by the Principles of Ethics of the Association.

MR. HUME: May I just interrupt to indicate that ethics here is used in a different sense than in the ethics we have been discussing.

THE CHAIRMAN: You mean in the proper sense?

MR. HUME: In the proper sense.

MR. FRAWLEY: The way we use it in the legal profession.

MR. CONDER: These include:

1. The calling of a pharmaceutical manufacturer is one



1 dedicated to a most important public service, and  
2 such public service shall be the first and ruling  
3 consideration in all dealings.

4 2. The pharmaceutical manufacturer must produce his  
5 preparations only under proper conditions and with  
6 scrupulous faithfulness to required standards of  
7 quality.

8 3. Preparations must be labelled and merchandised only  
9 in a manner free from misrepresentation, misleading  
10 practices of all kinds and in entire harmony with the  
11 highest standards of commercial morality and  
12 professional ethics.

13 4. Pharmaceutical manufacturers must constantly and  
14 conscientiously strive to advance the science and  
15 elevate the calling of manufacturing pharmacy to the  
16 highest plane of public value, to the end that it  
17 may best and most completely serve the medical  
18 profession and the public.

19 Advertising

20 On June 15, 1959, our Association adopted  
21 an extensive list of "Principles of Ethical Drug Promotion",  
22 a copy of which follows. Briefly, this requires that all  
23 advertisements of member companies shall contain "complete,  
24 conservative and accurate information concerning medicinal  
25 agents", and that claims shall not be stronger than warranted  
26 by the evidence.

27 PRINCIPLES OF ETHICAL DRUG PROMOTION

28 We, members of the Canadian Pharmaceutical  
29 Manufacturers Association, recognizing our responsibilities  
30 and obligations to promote the public welfare and to maintain





1 honourable relations with the medical and pharmaceutical  
2 professions, with associated sciences, and with the public,  
3 do pledge ourselves to the following statement of principles:

4           1. Prompt, complete, conservative and  
5 accurate information concerning medicinal agents shall be  
6 made available to the medical and pharmaceutical professions;

7           2. Any statement involved in product  
8 promotional communications must be supported by adequate  
9 and acceptable scientific evidence. Claims must not be  
10 stronger than such evidence warrants. Every effort must  
11 be made to avoid ambiguity and implied endorsements.  
12 Whenever market, statistical or background information or  
13 references to unpublished literature or observations are  
14 used in promotional literature, the source must be available  
15 to the physician upon request;

16           3. Quotations from medical literature or  
17 from the personal communications of clinical investigators  
18 in promotional communications must not change or distort the  
19 true meaning of the author;

20           4. If it is necessary to include compari-  
21 sons of drugs in promotional communications, either written  
22 or verbal, such comparisons must be used only when they are  
23 constructive to the physician and made on a sound professional  
24 and factual basis. Trade marks are private property that  
25 can be used legally only by or with the consent of owners  
26 of trade marks;

27           5. The release to the lay public of informa-  
28 tion on the clinical use of a new medicinal agent or the  
29 new use of an established drug prior to adequate clinical  
30 assessment and presentation to the medical profession is not



1 in the best interests of the medical profession or the  
2 layman;

3 6. All medical claims and assertions contained  
4 in promotional communications shall have medical review  
5 prior to their release.

6 Any violation of these principles brought  
7 to the attention of the General Manager of the Canadian  
8 Pharmaceutical Manufacturers Association shall be referred  
9 by him to the Board of Directors.

10 MR. FRAWLEY: Going back to your affiliate  
11 members, they are people who were suppliers to the industry?

12 MR. CONDER: That is correct.

13 MR. FRAWLEY: And they are still suppliers  
14 to the industry?

15 MR. CONDER: That is right.

16 MR. FRAWLEY: They are not listed in --

17 MR. CONDER: They will be included in our  
18 membership list in the back.

19 MR. HUME: They are in Appendix B.

20 MR. CONDER: That is right, all the members  
21 are in Appendix B, full, associate and affiliate.

22 MR. FRAWLEY: You say these two come under  
23 the "affiliate" category. You say that in your brief in  
24 Appendix A, and when I look at Appendix B, the members of  
25 your association, do I find the affiliate members?

26 MR. CONDER: Yes you do.

27 MR. FRAWLEY: They are all there?

28 MR. CONDER: They are all there, all  
29 companies are there. We have four affiliate members.

30 MR. FRAWLEY: Would it be much of a job to



1 pick off those that are affiliate suppliers rather than  
2 pharmaceutical manufacturers?

3 MR. HUME: How many are there, Mr. Conder?

4 MR. CONDER: There are four of them.

5 MR. HUME: Perhaps through the luncheon  
6 adjournment we can take them off.

7 MR. FRAWLEY: Ingram and Bell would be one?

8 MR. CONDER: No sir, Ingram and Bell are  
9 manufacturers and distributors of pharmaceuticals in Canada.

10 MR. HUME: We will advise you, Mr. Frawley.

11 MR. CONDER: In conclusion, we wish to  
12 thank you for the privilege of presenting this submission  
13 to the Restrictive Trade Practices Commission, and are at  
14 your disposal to answer any questions you may have concerning  
15 the contents of this document.

16 APPENDIX B

17 MEMBERS

18 of the

19 CANADIAN PHARMACEUTICAL MANUFACTURERS ASSOCIATION

20 Abbott Laboratories Ltd.,  
21 1350 Cote de Liesse Road,  
22 Montreal, P.Q.

23 Ames Company of Canada Ltd.,  
24 1131 Bloor Street West,  
25 Toronto, 4, Ontario.

26 Anca Laboratories,  
27 P.O. Box 96, Station "O",  
28 Toronto 16, Ontario.

29 Anglo-French Drug Company Ltd.,  
30 209 St. Catherine St. East,  
Montreal, 18, P.Q.

Arlington-Funk Laboratories Div.,  
U.S. Vitamin Corp. of Canada Ltd.,  
1452 Drummond Street,  
Montreal, P.Q.



- 1 Astra Pharmaceuticals (Canada) Ltd.,  
1004 Middlegate Road,  
2 Cooksville, Ontario.
- 3 Ayerst, McKenna & Harrison, Ltd.,  
4 P.O. Box 6115  
Montreal, P.Q.
- 5 Baxter Laboratories of Canada Ltd.,  
6 P.O. Box 760,  
Alliston, Ontario.
- 7 Beecham Research Laboratories Ltd.,  
8 P.O. Box 99,  
Weston, Ontario.
- 9 Bristol Laboratories of Canada Ltd.,  
10 286 St. Paul Street West,  
Montreal, P.Q.
- 11 The British Drug Houses (Canada) Ltd.,  
12 Barclay Avenue, Queensway,  
Toronto, 18, Ontario.
- 13 Burroughs Wellcome & Co. (Canada) Ltd.,  
14 P.O. Box 159,  
Montreal, P.Q.
- 15 Calmic Limited,  
16 220 Bay Street,  
Toronto, Ontario.
- 17 Canada Duphar Limited,  
18 Box 444,  
London, Ontario.
- 19 Casgrain & Charbonneau Limitee,  
20 445 St. Lawrence Blvd.,  
Montreal, P.Q.
- 21 Ciba Company Ltd.,  
22 200 Metropolitan Blvd.,  
Dorval, P.Q.
- 23 Lederle/Cyanamid of Canada Ltd.,  
24 635 Dorchester Blvd., West.,  
Montreal, P.Q.
- 25 Charles E. Frosst & Company,  
26 P.O. Box 247,  
Montreal, P.Q.
- 27 Geigy Pharmaceuticals,  
28 Division of Geigy (Canada) Ltd.,  
2626 Bates Road,  
29 Montreal, P.Q.
- 30



- 1 Glaxo-Allenburys (Canada) Ltd.,  
2 52 Bator Road,  
3 Weston, Ontario.
- 4 J. F. Hartz Company Ltd.,  
5 32-34 Grenville Street,  
6 Toronto, 2, Ontario.
- 7 Hoechst Pharmaceuticals of Canada Ltd.,  
8 3400 Namur Street,  
9 Montreal 16, P.Q.
- 10 Hoffman-La Roche Ltd.,  
11 1956 Bourdon Street,  
12 St. Laurent, Montreal, P.Q.
- 13 Frank W. Horner Limited,  
14 P.O. Box 959,  
15 Montreal, P.Q.
- 16 Ingram & Bell Limited,  
17 256 McCaul Street,  
18 Toronto, Ontario.
- 19 Lakeside Laboratories (Canada) Ltd.,  
20 24 Wellington Street West,  
21 Toronto, 1, Ontario.
- 22 Laurentian Laboratories Ltd.,  
23 442 St. Gabriel Street,  
24 Montreal, P.Q.
- 25 Eli Lilly & Company (Canada) Ltd.,  
26 P.O. Box 4037, Terminal "A",  
27 Toronto, Ontario.
- 28 Mallinckrodt Chemical Works Ltd.,  
29 372 St. Paul Street West,  
30 Montreal, P.Q.
- May & Baker (Canada) Ltd.,  
180 Bellarmin Street,  
Montreal 11, P.Q.
- Mead Johnson of Canada Ltd.,  
111 St. Clair Ave. West,  
Toronto 7, Ontario.
- Merck Sharp & Dohme of Canada Ltd.,  
P.O. Box 899,  
Montreal, P.Q.
- The Wm. S. Merrell Company,  
Division of Richardson-Merrell Inc.,  
P.O. Box 158,  
Weston, Ontario.





ANGUS, STONEHOUSE & CO. LTD.  
TORONTO, ONTARIO

Conder

2014

- 1 Mowatt & Moore Limited,  
2 64 Prince Street,  
3 Montreal, P.Q.
- 4 Laboratories Nadeau Limitee,  
5 100 St. Paul Street West,  
6 Montreal, P.Q.
- 7 Ortho Pharmaceutical (Canada) Ltd.,  
8 19 Green Belt Drive, Don Mills,  
9 Toronto, 12, Ontario.
- 10 Parke, Davis & Company Ltd.,  
11 P.O. Box 2100 Station "O",  
12 Montreal, P.Q.
- 13 Pfizer Canada,  
14 Division of Pfizer Corporation,  
15 5330 Royalmount Avenue,  
16 Montreal, P.Q.
- 17 Pitman-Moore of Canada Ltd.,  
18 E. B. Shuttleworth Division,  
19 14 Dyas Road,  
20 Don Mills, Ontario.
- 21 H. Powell Chemical Co. Ltd.,  
22 Bowmanville, Ontario.
- 23 Purdue Frederick Company Ltd.,  
24 Terminal Bldg.,  
25 207 Queen's Quay,  
26 Toronto, Ontario.
- 27 A. H. Robins Company of Canada Ltd.,  
28 5900 Cote de Liesse,  
29 Montreal, 9, P.Q.
- 30 Rougier Inc.,  
2055 Favard Street,  
Montreal, P.Q.
- Sandoz Pharmaceuticals,  
Division of Sandoz (Canada) Ltd.,  
220 Metropolitan Blvd.,  
Dorval, P.Q.
- W. E. Saunders Limited,  
P.O. Box 277,  
London, Ontario.
- R. P. Scherer Limited,  
1370 Argyle Road,  
Windsor, Ontario.
- Schering Corporation Ltd.,  
8370 Labarre Street,  
Montreal, P.Q.



1 G. D. Searle & Co. of Canada Ltd.,  
2 247 Queen Street East,  
3 Brampton, Ontario.

4 Smith, Kline & French I.A.C.,  
5 300 Laurentian Blvd.  
6 Montreal, P.Q.

7 E. R. Squibb & Sons of Canada Ltd.,  
8 P.O. Box 599,  
9 Montreal, P.Q.

10 Strong Cobb Arner of Canada Ltd.,  
11 575 Niagara Blvd.,  
12 Fort Erie, Ontario.

13 The Upjohn Company of Canada,  
14 865 York Mills Road,  
15 Don Mills, Ontario.

16 Henry K. Wampole & Co. Ltd.,  
17 Perth, Ontario.

18 Warner-Chilcott Laboratories Co. Ltd.,  
19 Division, Warner Lambert (Canada) Ltd.,  
20 727 King Street West,  
21 Toronto, 2B, Ontario.

22 Winthrop Laboratories of Canada Ltd.,  
23 Aurora, Ontario.

24 John Wyeth & Brother (Canada) Ltd.,  
25 2109 Ottawa Street,  
26 Walkerville, Ontario.

27 THE CHAIRMAN: We will adjourn for lunch,  
28 and following lunch period Professor Dixon will have some  
29 discussion of the brief which he has prepared, and you  
30 will then come back to answer questions?

MR. CONDER: Fine.

---Luncheon adjournment.



MT/dpw

1 --- On resuming at 2.20 p.m.

2 THE CHAIRMAN: We will resume the hearing,  
3 ladies and gentlemen. Mr. Dixon?

4 MR. HUME: Mr. Chairman, in introducing Dr.  
5 Brian Dixon, I would like to avoid if I could, a long  
6 series of questions and answers that are so tiresome in  
7 qualifying Dr. Dixon. Dr. Dixon, I don't think it would  
8 be immodest of you if you would, without my questions,  
9 just indicate for the record your qualifications.

10 THE CHAIRMAN: The ones he thinks worth  
11 mentioning.

12 DR. DIXON: I will try to keep them to a  
13 minimum. I have my B.A. in economics from the University  
14 of Manitoba; my Master of Commerce from the University of  
15 Toronto, and my Ph.D. in economics and marketing from the  
16 University of Michigan.

17 I have taught at the Universities of Michi-  
18 gan, Assumption University, McMaster University, and I  
19 am presently teaching business economics and marketing in  
20 the School of Business at Queen's University.

21 I have had a number of publications,  
22 generally in the field of business economics in the  
23 relationship of the firm and competition. I don't think  
24 any listing of these is appropriate, but this area is the  
25 one that I am concerned with.

26 MR. HUME: Thank you, Doctor. At the  
27 request of the Canadian Pharmaceutical Manufacturers'  
28 Association you prepared an economic analysis, which is  
29 dated September 15, 1960, and which you submitted to the  
30 Ontario Select Committee on Drugs?



1 DR. DIXON: That is correct.

2 MR. HUME: May that be entered, Mr. Chairman,  
3 as Exhibit T-10? It is Appendix C of the brief. That  
4 could be entered as an exhibit. It is not the intention  
5 to read it unless you wish it.

6 THE CHAIRMAN: He is not going to read it  
7 in full.

8 MR. HUME: I am going to call on Dr. Dixon  
9 to discuss it.

10 THE CHAIRMAN: The document I think has  
11 been described by Mr. Hume as an Economic Analysis of  
12 the pharmaceutical manufacturing industry in Canada.

13 MR. HUME: Doctor, would you now proceed to  
14 discuss this exhibit, please.

15 DR. DIXON: Yes. Before I discuss this  
16 exhibit I would like to place it in a frame of reference.  
17 This was not drawn up for a hearing of the present Commis-  
18 sion, and therefore some of the material in it is not  
19 concerned with competitive effects as such. As an expert  
20 witness I would presume in these circumstances to be  
21 primarily talking about effects of competition. I will try  
22 to relate this into the brief. If I could do this initially.

23 It is a little hard - more than a little  
24 hard - it is extremely difficult to try to evaluate what  
25 is meant by reasonable profits, reasonable amounts of  
26 promotional activities, reasonable pricing policies in any con-  
27 text except a study of the competitiveness of the industry.  
28 There has been some considerable argument on definitions  
29 of workable competition, and so on, as far as performances,  
30 but it would seem to be a pretty general consensus of



1 economists in this matter that what one is looking for is  
2 the effect of competition, this being variously defined,  
3 but the prime tests of this being still essentially struc-  
4 tural. That is, the nature of the concentration, the  
5 collusion or lack of it in the industry, the difficulty  
6 of entry. If it is thought that a level of adequate compe-  
7 titon exists, then this is in effect a measuring rod  
8 against which the other factors such as profits, prices  
9 and so on must be measured.

10 In other words, it is conceivable the rate  
11 of return on an investment of 100% in a new innovating  
12 firm would be much more reasonable than a rate of return  
13 of 5% on a staid old monopoly by this kind of definition.  
14 If it was in fact in a monopoly position, this well might  
15 be an unwarranted profit rate.

16 In this connection in the beginning part of  
17 the exhibit I talk about these three points that at least  
18 to some degree I feel are related to evaluating competition  
19 in the industry. One is concentration. To summarize  
20 first, it would appear that the level of concentration in  
21 this industry is lower than many other industries in this  
22 country.

23 MR. FRAWLEY: Dr. Dixon, would it bother you  
24 if I interrupted you to ask you right there to define the  
25 word "concentration"?

26 DR. DIXON: Concentration, there may be a  
27 number of formal ways of defining it, but essentially it  
28 means the degree to which the sales in the industry are  
29 concentrated in the hands of firms. That is, a high  
30 degree of concentration would mean most of the sales are





1 in the hands of a very small number of firms; a low  
2 degree would mean the reverse.

3 It is a little difficult to get information  
4 to evaluate this on because statistics are not available  
5 in precisely this form. I use in this particular case  
6 the data in the Medicinal and Pharmaceutical Preparations  
7 Industry report, which is not actually on firms; it is  
8 on plant. This industry is, however, not heavily involved  
9 in multi-plant operations, and this seemed reasonable.  
10 In this technique there are figures of employment; that  
11 is, concentration of employment by firms And then to I  
12 presume that employment and output are equal and finding there a  
13 dangers in this too. This is another technique that has  
14 been used.

15 I think the second thing is the conclusions  
16 which were drawn and to which I refer in the footnote on  
17 page 9 of my exhibit, the conclusions which are similar  
18 to my own, the concentrations in this industry are low.  
19 The bases of using the information I did are corroborated  
20 by the reference on the study of Industrial Concentration,  
21 Royal Commission on Canada's Economic Prospects.

22 THE CHAIRMAN: Relatively low?

23 DR. DIXON: In the bottom quarter of the  
24 30% of industries in Canada on the basis of this reference,  
25 which certainly places it fairly well down the scale of  
26 concentration. This is really all I would say with  
27 reference to the number of firms concentration except  
28 perhaps to draw attention to the remark again on page 9  
29 that the Canadian Pharmaceutical Preparations Industry  
30 has a rather larger number of firms proportionate to the



1 relative population of the two countries than its U.S.  
2 counterparts on the basis of information available. It  
3 is approximately 1,200 companies in the U.S. as opposed  
4 to 200 in Canada, which is a percentage ratio tighter  
5 than the ratio of population, the ratio of 1 to 6 while  
6 the population is 1 to 10 or 1 to 11 perhaps, which,  
7 taken in conjunction with the concentration would tend to  
8 indicate a situation at least receptive to a high degree  
9 of competition.

10 As far as entry is concerned, the main  
11 comment I would make here is in terms of what I would  
12 call difficulty of entry, and on this I would be concerned  
13 with the kind of capital it requires, the complexity of  
14 getting in.

15 The Commissioners have already heard an  
16 explanation how the trade firms can be relatively modest  
17 importers first and then move on to very minimal manufac-  
18 turing facilities, and then on to full-scale manufacturing  
19 facilities, and I would think relative to quite a number  
2 20 of other industries, the kind of capital investment or the  
21 process involved here is relatively simple. There are no  
22 immense barriers. I would conceive in heavy manufacturing  
23 where you may be involved in many millions of dollars of  
24 equipment to get started that there are obvious barriers  
25 in the market sense in that you have to convince the  
26 customer you can do a job, but this is I think a different  
27 kind of area than what is normally construed.

28 THE CHAIRMAN: Barrier in the competitive  
29 sense?

30 DR. DIXON: Barrier in the competitive sense.



1 THE CHAIRMAN: That would apply to any kind  
2 of product?

3 DR. DIXON: Yes. I was trying to differen-  
4 tiate - I was not meaning it might not be difficult, but  
5 it is not difficult in the sense of particular restrictions  
6 which affect the inflow of capital into the industry.

7 MR. WHITELEY: I wonder if that factor might  
8 not be more important in this than in some other industry.  
9 The person prescribing has to be completely convinced what  
10 he is using is the best, whereas with the product where a  
11 person's health does not depend, a person might be satis-  
12 fied with less rigorous standards when changing from one  
13 source of supply to another.

14 DR. DIXON: I think this would influence  
15 quality of the work done by the entering firm, but I  
16 think, as has been brought out by witnesses, this is not  
17 the prerogative of large firms. There are a number of  
18 small firms in the industry which have a good quality  
19 record, and even able to establish it without the necessity  
20 of capital investment or accumulation of large quantities  
21 of stuff which might be a restriction in some other cases,  
22 so I don't think - again I think this becomes a matter of  
23 competitive pressure once in as to how you can appeal vis-  
24 a-vis to the other firms.

25 Now, I am not a medical person, but this  
26 becomes a matter of evaluating fair performance, which  
27 is a different plane of the question.

28 On the collusion, I have no real comment  
29 except that I see no indication either in the material in  
30 the Green Book or in anything I have been able to study,



1 any data I have been able to study. But these are the  
2 only three points.

3               If you want prima facie evidence of a compe-  
4 titive industry, you have a low portion of concentration,  
5 a low concentration ratio. You have no, perhaps no  
6 staggering barrier, certainly none of the, at least from  
7 my view, from what I have seen, no evidence of collusion  
8 during those periods, and the industry on a structural  
9 basis can be taken to be competitive, and this is a real  
10 relevance of such things then as the rate of profits, the  
11 kind of promotional activity, the prices in the industry  
12 and all of these sections that I deal with in the exhibit  
13 were not necessarily in this prime reference, have to be  
14 taken like this. There is a basic presumption in this  
15 analysis that there is a competitive pressure exerted.  
16 But these phenomena of prices, profit and promotion are  
17 not occurring on a non-competitive market situation.

18               In connection with the profits I would like  
19 to just initially repeat the first statement in this  
20 section in the exhibit that as a measure of the extent of  
21 competition in an industry, it is difficult to get a  
22 direct inference from the rate of profits. There are  
23 many factors which make a direct comparison on an absolute  
24 sense very difficult. There is a difference in risk,  
25 difference in kind of skills involved, difference in the  
26 position in the cycle and only two things I will say to  
27 this: one, this basic presumption that if the industry is  
28 competitive, and there are not extreme barriers but if the  
29 rate of profit were too high in a competitive sense, that  
30 there would be a correction take place.



1                   The other point in connection with profits  
2 that I would like to draw on is that it is a common fact,  
3 regardless of how you compute them - I have used one, you  
4 can obviously use others - that is, a return on profits,  
5 and the thing in this case, I used the same technique for  
6 the various purposes. I happened to include reserve as  
7 well as surplus. That is a particular pet feeling of mine.  
8 It is higher than many other industries in an absolute  
9 sense, but I would suggest that there are a number of  
10 reasons which I spell out in the exhibit which taken in  
11 conjunction with the prima facie case of competitiveness  
12 suggests that this is not an unreasonable rate.

13                   You have got two things; one thing that I  
14 think is most important is that this is an industry which  
15 is - and I think this fact is sometimes - not only is it  
16 talked about a lot but is perhaps not appreciated, that  
17 it has been experiencing a kind of change in a very short  
18 period of time which is rather unusual. It is an explo-  
19 sion in many ways. The increase in sales in the last 10  
20 years has been very high. The change in the pattern of  
21 products has been very high. The change from sort of a  
22 standard, almost stable type of product which characterized  
23 the industry in its early years has been removed and it  
24 has been much more volatile industry in which products are  
25 jostling each other rather than, necessarily, anything less.  
26 Many new products are introduced of a different nature than  
27 some of the standard almost chemical run drugs that might  
28 have been characterized in the industry earlier.

29                   I think that this industry is almost purely  
30 an industry which is - I hate to use a technical word, a





1 professional word - it is Schumpeter in nature. It's the  
2 best example of an innovation originated industry that  
3 I have seen in a long while. That is, Professor Schumpeter  
4 had a theory of growth and of cycles which had to do  
5 with the main competitive force providing an - innovation  
6 and the cycle pattern being provided by the swelling and  
7 drop of innovations and it would seem that this industry  
8 is very close to this kind of an industry and part of  
9 this influence is a profit picture certainly, particularly  
10 when you are in a boom period in the sense of innovation -  
11 that is when a lot of new innovations are coming in. This  
12 is the case in this industry. There does tend to be a  
13 higher rate of profit - a higher rate of profit than there  
14 had been in the period of no introduction of new products.  
15 Conversely, it seems that the industry is not - cannot be  
16 anticipated to stay in this position continually.

17                   There are some real signs which have been  
18 commented on, not just by myself, but by people, for  
19 instance in the investment field and there have been quite  
20 a number of investment houses which have been taking a  
21 substantially poor view of pharmaceutical industry as an  
22 investment prospect over the next 10 or 15 years because  
23 of its anticipation in the drop of rate of innovation  
24 which will clearly affect the industry. I think that  
25 this cycle, if you want, this boom part of the cycle of  
26 this industry, has not been coinciding with the cycle  
27 pattern for industry in general. It has not been for  
28 the same reason, and as a matter of fact to the same  
29 extent these have been reversed. This industry has been  
30 experiencing a very rapid period of growth because of the



1 innovation, whereas much of the rest of the Canadian  
2 industry has been suffering rather a reverse situation -  
3 sort of a period of almost stagnation during much of this  
4 period, and by contrast, since it is innovations, the  
5 contrast comes between rates of return. That is, what I  
6 am saying is if we can go along for another 10 years -  
7 this is begging the question - it is conceivable that this  
8 situation will pull itself back the other way.

9               Unfortunately, the records on the taxation  
10 statistics which I used do not go back in any separable  
11 form before 1951 - 1953 - so you cannot take this back to  
12 see. That has to be a presumption on the basis of a  
13 pattern and it seems to be, on the basis of the evidence  
14 I could look at, a reasonable thing.

15               Some of the other factors affecting this  
16 research, this profit, this rate of profit, one is the  
17 business cycle, the other is this risk and obsolescence  
18 factor which I think must be considered that the industry  
19 themselves have a characteristic in which many of the  
20 products may well face a very short life and where it has  
21 been observed here, and in other places, that the relative  
22 market position of a firm can practically change overnight.  
23 If they don't keep up with innovations, keep up with as  
24 many new products as they can, their market can slip or  
25 could be very dramatically hindered by either doing or not  
26 doing a good job in product innovation.

27               This tends to vary towards a rate of return  
28 which is different from a stable industry in the sense of  
29 not having new product introduction, that having to gamble  
30 ahead so much, not knowing - not so much a gamble in the



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Dixon

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1 conventional sense as not knowing what is going to happen.  
2 There is a little uncertainty factor in this industry  
3 which is significant. You don't know whether this pro-  
4 duct around the corner is necessarily going to do something  
5 for you or not. This has an influence on the rate.

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C/PB/hm 1 Research without -- I am not going to try  
2 and talk about the percentage cost of research or anything  
3 of this nature except to make the observation because the  
4 industry is very strongly dependent on new product  
5 innovation, as new product development is a competitive  
6 weapon, this is crucial. This would appear to be a crucial  
7 test of the industry. There is a premium of research and  
8 this, I think, is going to become much more of a premium  
9 in the future. A firm that doesn't put its money in ever  
10 increasing quantity into research is likely to find itself  
11 in difficulty. They will be left behind.

12 This footnote on page 18 referring to the  
13 article in Fortune entitled "Drugs: The pace is getting  
14 furious" contrasts the number of firms in the U. S. industry  
15 and their policy towards this and some prognostication of  
16 how they are likely to be successful. This would seem to  
17 be something that is going to require much in the way of  
18 additional activity on the part of the firms; costly  
19 because it appears, and here I am going out of my field,  
20 it appears there is some kind of temporary -- permanent is  
21 going too far -- some kind of temporary ceiling in the  
22 road of discovery. They are bouncing against the difficulty  
23 of a ceiling. As, for instance, in the area of  
24 cancer agents and this appears to be much less certain of  
25 producing results, at least, in a short run period of time.  
26 There have been a lot of flare-ups. It is much less clearly  
27 defined in terms of theory. The type of expenditure is  
28 much more complex with less certainty of when or if the  
29 results are coming.

30 THE CHAIRMAN: I wa<sup>s</sup> wondering, Mr. Dixon,



1 assuming that situation becomes more rigid whether some  
2 of the companies might come to the conclusion they would  
3 be wasting their money for further research until some  
4 completely new avenue opened up.

5 DR. DIXON: Speaking as if I were advising  
6 a company, in view of the pattern, the competitive pattern  
7 and the effect of new products on competition, this would  
8 be a rather unwise thing for them to do. If some other  
9 firms get in and they don't have a comparable product the  
10 market itself swings rather abruptly. It would also seem  
11 this kind of research is not the sort of thing, ignoring the  
12 patterns, of trying to find an area which is something you  
13 can all of the sudden jump into. Perhaps there will be a  
14 time lag until they come up with something or there is a  
15 possibility of going completely on our own or we will buy  
16 the rights from somebody else.

17 THE CHAIRMAN: What I am thinking of they  
18 have pretty well explored the antibiotic field and if they  
19 don't see very much more in the tranquilizer field, they  
20 have gone as far as they are likely to go, unless something  
21 completely new comes on the scene, there is a break-through  
22 which will start them all going on research -- when you  
23 have exhausted the research on one break-through there might  
24 be a flatulent period. I was wondering when you were talking  
25 about the explosion. We have been going through, we should  
26 be coming to the end of, might we not get into that sort  
27 of thing?

28 DR. DIXON: Again I think I have observed  
29 a couple of these things, that have come to me as a person  
30 who only did first year science and saw the light as far as





1 my own inclinations were concerned. It seems there is a  
2 pattern developing at least in view of the examples I looked  
3 at of a continual flare of research in a wide variety of  
4 areas which is going on because there is so much uncertainty.  
5 One would be uncertain that one has reached the ceiling.  
6 The break-throughs don't accumulate necessarily to the  
7 point that -- for example, it has been mentioned and  
8 everyone knows about it, the accidental discovery of  
9 penicillin. For instance I know of one firm -- this is  
10 just purely by accident -- automatically test every compound  
11 that they have for certain characteristics against Cancer,  
12 against one or two other things, just automatically test  
13 even though there is no direct suspicion or understanding  
14 or theory, because there is the uncertainty factor.

15 THE CHAIRMAN: Waiting for another accident?

16 DR. DIXON: I think everybody in this sense,  
17 particularly in this industry or in the research process --  
18 I am not trying to suggest it is haphazard. There is always  
19 the possibility of ...

20 THE CHAIRMAN: Getting unusual results. They  
21 want to check to see.

22 DR. DIXON: That is really what I had in  
23 mind.

24 I go on in the rest of the report to talk about,  
25 to some extent about growth and then about prices. I think  
26 rather than talking directly on what I have said about prices  
27 here -- -- I think it is fairly clear. I would like to  
28 make some comment in the area -- since I have used them,  
29 of the indices that came up before because it obviously  
30 is a source of some problem. There is no question that



1 there is a lag in the product package although it is  
2 modified in the index. Not just in this index, but all of  
3 them, the point is quite logically raised , that many of  
4 these products we are talking about have come into play,  
5 most of this package was developed later. Is this index  
6 really relevant? This obviously becomes purely a matter  
7 of opinion at this stage because you can't really test  
8 this out, at least short of massive expenditures on different  
9 kinds of indices. All I would say in this regard as  
10 has been observed by the Commission and I think is clearly  
11 indicated elsewhere , among certain of these products that  
12 have been introduced, they have a fairly rapid downward  
13 movement in price and others wouldn't seem to have an  
14 upward movement in price of any consequence, even some of  
15 the ones, for instance in the Green Book showing some  
16 stability of price. I would suggest that the injection of,  
17 or if the indices could have been adjusted which, in fact,  
18 they can't be if they are going to have any stability -- this  
19 is a problem of some consequence in all these areas, that  
20 these indicate, if anything, that the index may have, if  
21 anything, overstated the price rise. That is just one  
22 point. Two, this statement has been made by Professor  
23 Jules Backman who is fairly respected as an outstanding  
24 authority on pricing in which he drew the same conclusion  
25 with reference to this particular index in the U.S., that  
26 is, the Pharmaceutical prices.

27 THE CHAIRMAN: Mr. Dixon, in industries of  
28 this kind where a new product results from often accidental  
29 and fairly expensive research, would you anticipate in a  
30 period of slowly rising prices, increasing inflation, would



1 you anticipate that the prices of such a product over the  
2 first few years after it is introduced would it rise or  
3 would you anticipate that after there has been a  
4 write-off within a reasonable period of time of the heavy  
5 cost of discovery and development, the more likely  
6 tendency would be prices would drop rather than raise?  
7 What would be your views on that?

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1 THE CHAIRMAN: What would be your views on  
2 that as an economist?

3 DR. DIXON: The first thing I think I  
4 would have to say is that in the short run it is very  
5 difficult to say anything valid about the relationship  
6 between cost and price.

7 The only definitive economic statement on  
8 the relationship between the two is I think it is  
9 generally accepted that in the long run the price tends  
10 to increase, but in the short run, in the kind of economic  
11 structure we have today, if a firm has a limited product  
12 line, to me - and as I say I have not studied individual firms  
13 in this case, but I have the same reference as Mr. Conder  
14 had - the only reasonable market would be on some kind of demand-  
15 oriented basis, a full line basis, not on a one-  
16 product basis. The company in fact is not selling a parti-  
17 cular drug; the company is selling this whole package of  
18 products.

19 THE CHAIRMAN: Take the other aspect of it  
20 here that so often appears to happen in this industry,  
21 that one company develops a new product. Then within the  
22 next period, maybe a year or so, or a year-and-a-half,  
23 or two years, two or three or four other companies produce,  
24 not identical products, but very similar products; doesn't  
25 it do the same thing?

26 I would think it would have some effect  
27 upon the question of increase in price on the part of the  
28 first originator, would it not?

29 DR. DIXON: At least on setting the price  
30 at some particular level, and then whether it would drop



1 or not ---

2 THE CHAIRMAN: Would it affect the prospect  
3 of the original inventor or discoverer raising it?

4 DR. DIXON: In the sense there would be a  
5 new price. Really there is no raise involved here, but  
6 starting out what you have constitutes a fairly high  
7 price with the anticipation of it coming down.

8 THE CHAIRMAN: What I am trying to get at  
9 is whether that would not make it more difficult to raise  
10 the price and perhaps increase the likelihood that the  
11 price might come down.

12 DR. DIXON: I made a note specifically on  
13 that. This came up this morning with this business  
14 when you were talking about this before, if I might jump  
15 ahead a minute - that this worry all the time, if you will,  
16 about the entrance is certainly a pressure against  
17 charging a high price, and with the competition in this  
18 industry as it is today, because of this characteristic  
19 which I think not only concerns the approximate substitutes  
20 with imperfect products in existence, but with potential  
21 substitutes around the corner, I would think it reasonable  
22 if a firm had set a very high price or started to move it  
23 up, and a competitor came in with another product, taking  
24 some of the market away from the firm, that this would be  
25 pretty severe.

26 From a purely personal point of view, there  
27 is a concept, if you will, of penetration which I think  
28 has some relevance here, that you would presumably try to  
29 set your price so that you might hold your position after  
30 the competitors enter as far as the price is concerned.





1 If you try to tumble down, there is always the risk that  
2 you don't tumble down quickly enough, and if you are  
3 still in there, your price may well be too low and your  
4 mark-up completely disappears. It may be under the cir-  
5 cumstances more difficult to get it back than to not have  
6 lost it in the first place.

7 THE CHAIRMAN: In this industry you seem to  
8 be faced with the fact that you may have a competitor,  
9 the almost certain fact that you will have.

10 DR. DIXON: It is our thought that someone  
11 will come over with a similar therapeutic agent. That  
12 seems to be the self-evident fact of life in this  
13 industry.

14 THE CHAIRMAN: Wouldn't it be likely to  
15 make it difficult for the originator to increase his  
16 price? If the competitors are coming in within a reaso-  
17 nable period after that, wouldn't it be likely to have a  
18 downward pressure on price that might lead to prices being  
19 lower?

20 DR. DIXON: I would think that the price -  
21 there would certainly be this tendency rather than the  
22 reverse, yes. As I say, the main pressure is the pressure  
23 from new products, and this will affect all the other  
24 competitive aspects.

25 THE CHAIRMAN: Isn't it likely that in this  
26 industry - isn't it more likely that a new product that  
27 has been introduced and has been on the market, that the  
28 price would likely be forced down by reason of competitive  
29 influences?

30 DR. DIXON: I think generally, yes.



1 THE CHAIRMAN: Rather than go up?

2 DR. DIXON: Yes, there may be one big excep-  
3 tion in the sense that if the product is completely by-  
4 passed as a therapeutic agent you might find ---

5 THE CHAIRMAN: It disappears.

6 DR. DIXON: Or it may stay because sometimes  
7 there are some uses, but the price may just stay there;  
8 in other words in the future the price will remain,  
9 nothing is going to happen, the sales may go way down,  
10 but the price responsiveness to the demand is not as  
11 significant in this industry as the response to what the  
12 product will do.

13 That is basically the consumer is more  
14 concerned about the therapeutic effect very directly,  
15 and says, "I want this to do something for me". If the  
16 new product comes along and does much better, this will  
17 outweigh the fact that the old product is lower in price,  
18 much more so in this industry than in others.

19 THE CHAIRMAN: You may get the separate  
20 case where loss of a particular product much more drasti-  
21 cally reduced that, even though it has some use like that,  
22 some purpose, somebody wants it because the manufacturers  
23 have been making friends by reason of what they made years  
24 before. He may have to charge a higher price, conceivably,  
25 because he is making so little out of it.

26 DR. DIXON: Yes, certainly the general  
27 pressure will be in a downward press. Coming back to  
28 this cost of living index, if you will, I think it is  
29 probably quite reasonable to say that the index has  
30 certainly not understated the price rise. There is the



1 possibility it has even overstated the price rise because  
2 again it is not direct evidence of competitiveness.

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4 Taken in conjunction with the other things,  
5 the price performance in the industry is certainly a  
6 fairly modest, has been a fairly modest one. We have  
7 less than average increase in price over the period of  
8 time that I have been able to study the data.

9 With regard to the promotional strategies,  
10 that is because of the part of competition in the industry,  
11 too. There are a number of comments, a number of remarks,  
12 that I would like to make to illustrate what I said in  
13 the exhibit.

14 Now, regarding competition - and this came  
15 out to some extent this morning - there is a real test of  
16 the market in these promotional activities, and if a firm  
17 or firms are doing things with the market, it is not some-  
18 thing which is going to reflect in the living cost relation-  
19 ship. That is, it is going to cost a lot of money without  
20 bringing in any return.

21 Let us take the specific case of direct  
22 mail as an example. The queerest thing in this industry  
23 is, there is no set promotional method. That is, not all  
24 firms use equal proportions of detailmen, direct mail,  
25 and so on. Some of them use no direct mail; others use  
26 a great deal and if one went on these techniques in effect  
27 saying it is no good, it is not doing its job, then the  
28 fact that some other firms are not using it at all would  
29 put a tremendous competitive liability on the firm that  
30 did.



1 If all of them were using it, one could  
2 argue that they would all be in it together, but it is  
3 not going to change the relative position. But when you  
4 have these varying methods, it in fact would change their  
5 relative position in terms of the net that they were able  
6 to get out of their activities, if they were doing some-  
7 thing which was not producing an effect on the market.

8 THE CHAIRMAN: They have different views as  
9 to what is effective for their purpose?

10 DR. DIXON: Probably. This is certainly  
11 reasonable and in fact will have a different effect  
12 depending on the kind of products, the background of their  
13 company, the reputation it has built up, and so on, and  
14 it does allow for a state of flux. So it is more likely  
15 a test of the market is operating under the evidence that  
16 I think is existing in the industry, and these things are  
17 in fact performing a function which has been verified by  
18 the market in the only way that is really valid for a  
19 firm to look at it, and that is, is the activity justified  
20 by the results?

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1 Something that just occurred to me I think  
2 might be useful. This industry to some extent is regarded  
3 as being pretty unique in the relationship between the  
4 consumer and the manufacturer, which makes it a little  
5 bit more difficult to evaluate the kind of behaviour pattern  
6 as to whether it is normal and so on, and at lunch I must  
7 confess I discovered another industry which is virtually  
8 identical.

9 THE CHAIRMAN: You think there are others?

10 DR. DIXON: The prescription element in this  
11 peculiar relationship, the customer is one who buys it  
12 but has nothing to say or very little to say with the choice  
13 -- the text book publishing industry. Here you have a  
14 situation where a college professor is the one who prescribes  
15 a book, but doesn't pay for it. The student is the one  
16 who pays for it.

17 THE CHAIRMAN: He has to get some revenue  
18 out of it?

19 DR. DIXON: This is the case of the exercise  
20 of monopoly in a small area by the professor, but it is a  
21 little different. Here you have exactly the same kind of  
22 circumstance in that you have a manufacturer, you have a  
23 professional who is also in effect a buying agent for the  
24 consumer who has no control over the process, so I think  
25 it is significant that the pattern of promotion used in  
26 the text book industry is, if you took the reference to  
27 the industry out, virtually the same. That is, the text  
28 publishers have detailmen; their function is very similar.  
29 They go around and they talk to me and they show me products  
30 that they have available. They try to explain why they are





1 good. They provide samples, desk copies, that I can use  
2 and test and check out before I recommend them.

3 THE CHAIRMAN: They ask you to review them?

4 DR. DIXON: That becomes a different  
5 phenomena really, and they are generally not too successful  
6 -- it is an honour, of course. This again compares to the  
7 clinical investigation, if you will.

8 They also use direct mail for very much the  
9 same purpose. That is, in other words the pattern of  
10 promotion in this other industry, which has the same  
11 relationship between the consumer and the manufacturer,  
12 produces a pattern of competitive behaviour which is very  
13 simple. Also in this industry, the key competitive factor  
14 is new product introduction, bringing out new texts, new  
15 issues. This is the thing that keeps the firm alive. The  
16 publishing firms, text publishing firms that have been most  
17 successful, have been the firms that have consistently  
18 brought out good new labels. Good new brands. Good new  
19 texts.

20 I don't want to belabour the comparison, but  
21 I think it is interesting that when you get a circumstance  
22 that is similar that indicates the pattern is not dissimilar.

23 The only other thing that is of relevance  
24 that I talked about in the exhibit is the issue of patents.  
25 In patents, this seems to me to tie back to the competitive  
26 force in the industry, to the relation of this industry,  
27 its innovational nature, and at this point I would like to  
28 quote a statement, or paraphrase a statement that Professor  
29 Schumpteter made with reference to patents. I think it  
30 is appropriate. He compared patents and some other temporary



1 monopolies by primaril referring to patents as similar to the  
2 brakes on an automobile, which were necessary to have in  
3 order to go quickly. That is, you wouldn't dare drive a  
4 vehicle rapidly without having brakes. These patents are  
5 in effect brakes to the extent that they are effective on  
6 the competitive process for short periods of time, whereas  
7 the necessary ingredien' in the long run is the competitive  
8 process of innovation. This is relative to this industry  
9 because product development and improvement is a very  
10 strong competitive force, and it is probably the main  
11 competitive factor because this is what the market is  
12 primarily interested in. Therefore this comment of his  
13 I think is quite relevant that these temporary brakes, if  
14 you will, if they contribute to this process of continual  
15 development, leave a net positive pressure on the industry  
16 over a time. The other point that I think I would raise  
17 in connection with this is that I am not sure that the  
18 position of a patent in itself particularly affects the ability,  
19 apparent ability of the industry, to bring out comparable  
20 therapeutic agents. It certainly doesn't seem to last the  
21 way patent protection does in some other industries. I think  
22 that was brought out this morning. Even a patented product  
23 seems to hold the fort for a relatively short period of  
24 time, and in some cases it doesn't hold the fort at all.  
25 A patent is taken out and the next day or week or month  
26 somebody else comes out with something that does the same  
27 job.

28 I am not suggesting it does not have any  
29 effect, but I think under the circumstances in the industry  
30 it has a relatively short-run effect, which is a reasonable



1 thing to expect in view of the contribution that it makes  
2 towards the overall competitiveness of the industry over  
3 time in this regard.

4 In this connection you will notice in the  
5 exhibit that I talked about cross-licencing, and here I  
6 confess that there are all sorts of opinions, but I made  
7 the suggestion that it is conceivable that without cross-  
8 licencing there would be greater competitive pressure on  
9 the industry than there is with it, because given product  
10 development as the main competitive force in the industry,  
11 the firms have to continue to develop new products, if they  
12 haven't the alternative of ineffect tapping the competitor  
13 on the back and saying "me too". This puts an incessant  
14 pressure on the firm to continue improving his product and  
15 doing a job in getting it out to the market.

16 MR. CARIGNAN: Does that mean that you have  
17 come to the conclusion that ---

18 DR. DIXON: I won't go as far as this. I  
19 am just raising the point that it seems to me it is less  
20 than clear, the net effect of the licencing feature, one  
21 way or the other. I think you can put a reasonable  
22 argument both ways. We have had some examples this morning  
23 of argument in one direction, and I think this argument  
24 you can argue the other way, that it is far from clear, and  
25 I think it would require a much more sophisticated analysis  
26 and much more detailed statistical investigation before  
27 you can in effect draw conclusions.

28 MR. WHITELEY: Both with regard to that  
29 particular point of patents and research innovation, you  
30 appear to treat the industry on a world basis, You don't



1 appear to make any distinction in regard to the situation  
2 as it relates to Canada as an individual country.

3 DR. DIXON: In what way, sir?

4 MR. WHITELEY: Take the aspect of patents.  
5 To what extent are these patents actually Canadian develop-  
6 ments?

7 DR. DIXON: Well, frankly, I am not sure.  
8 I can't see -- given the admixture of ownership basis for  
9 the industry in Canada, I can't see that the point of  
10 origin of the patent or the expenses of it has any  
11 particular influence on the Canadian industry.

12 It seems to me the second point is that there  
13 are a variety of firms bringing out a variety of products  
14 regardless of where they were developed; it has a competi-  
15 tive effect one upon the other within the Canadian manu-  
16 facturing economy.

17 MR. WHITELEY: In cross-licencing, you see  
18 no distinction in the provision of cross-licencing where  
19 the bulk of patents originate outside the country and  
20 provision of cross-licencing where it originates within  
21 the country?

22 -

23

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R/dpw

1                   There presumably could be a competitive  
2 effect if the firm - the patent originating outside the  
3 country was by a firm which did not operate in the country  
4 to the extent that it would not be - the cross-licencing  
5 would not be adding to the numbers of firms producing  
6 that item within the boundaries of Canada but if the firm,  
7 the foreign firm which owned the patent operated within -  
8 operated a manufacturing operation within Canada as well  
9 (1) I would presume that they would be able to use their  
10 own patent in Canada as well, or in the United States.

11                   MR. WHITELEY: Well presumably extending  
12 the argument, the removal of cross-licencings, which you  
13 say might have an accumulating effect on innovation, to  
14 the small - to the firm in some country other than Canada.

15                   DR. DIXON: It is entirely conceivable sir,  
16 but I think what I am suggesting is the result would be  
17 felt in the competitive level here.

18                   MR. WHITELEY: No, the suggestion is that  
19 this small Canadian market can in some way influence a  
20 firm in some much larger market in its behaviour.

21                   DR. DIXON: One, I don't think that this is  
22 as far-fetched in terms of size itself. Now the incre-  
23 mental value of the sales I would think would be pretty  
24 significant to most firms in most other countries. Let's  
25 take a British pharmaceutical manufacturer where the  
26 market being one-quarter of their market it would still  
27 be of pretty considerable consequence. (2) This still has  
28 an effect on the Canadian-owned firms in the industry and  
29 would, if anything, be more - and also on subsidiary  
30 operations it would - what I am sort of leading up to, I





1 am not sure the effect is going to be significant one way  
2 or another with the staying on or staying off. I am not  
3 at all sure. I don't think the issue, going back behind  
4 it - what I am really concerned about, I don't think the  
5 issue of patents or the existence of patents in this  
6 industry has any long run adverse competitive effect but  
7 I think in general because of the nature of the competition  
8 in the industry it tends to have a positive effect on the  
9 country.

10 This product development is the most impor-  
11 tant thing. A firm can't survive without it. In fact,  
12 when a firm says - in the absence of this existence of  
13 patents that they don't have the product, I don't have it,  
14 I can't sell. I can't compete and in view of the spread  
15 of firms who have a fairly substantial position in the  
16 market - this is not a market dominated just by a couple  
17 of firms and just followed by a great number of very small  
18 firms who have to follow along. A substantial number of  
19 fairly significant competitors. It seems inconceivable  
20 to me that one of these people or two or a number of them  
21 would just say "I give up. I can't". Rather the reverse.  
22 I think they would intensify their activities in order to  
23 compensate for or to prevent an advantage occurring perma-  
24 nently to a competitor.

25 If I could, I would like to make a couple  
26 of remarks which aren't merely an outgrowth of this exhi-  
27 bit but which - one is in connection with brand name and  
28 trademarks.

29 I notice a reference in the Green Book on  
30 page 219 which gives the impression, at least to me, that



1 the process of individual branding was something that is  
2 unique. That is, putting an individual brand on each  
3 product was more common to the pharmaceutical industry;  
4 that the normal tendency, they were saying, was to put a  
5 family brand or a company brand on all the products of  
6 the company.

7 I would like to suggest that this is not a  
8 necessary condition at all. I think the factor that  
9 determines whether a brand is individual or family depends  
10 primarily on the degree of distinctiveness of the indivi-  
11 dual product; the different uses to which it is put; the  
12 degree to which you can group all the products of a  
13 company under one brand without creating confusion.

14 For instance, on the automobile industry,  
15 the products are far less but the practice of individual  
16 branding is typical. That is, you don't have companies -  
17 in electrical appliance industry it is split. You use  
18 a family brand or you use an individual brand but generally  
19 you will find branding and individual branding particularly  
20 appear wherever the characteristics of the product (1) are  
21 hidden in an observable sense from the consumer, or  
22 (2) where there is a real - a possibility of a difference  
23 between this product and some other product in any measu-  
24 rable way.

25 This is not - this process of individual  
26 branding of products is not a phenomenon which is in any  
27 way unique to the pharmaceutical industry or particularly  
28 important to it. It happens in the food industry. This  
29 is quite common. Depending on the nature of the product  
30 you have either a family brand or the other way - it is



1 not in any way in connection with the effectiveness, in  
2 the sense but with regard to terms. The other thing is  
3 there would be some difference - a very general tendency  
4 towards trademarking, and this branding - I would rather  
5 use this term - under a brand name of a product when there  
6 is a definite distinctiveness - this is something that  
7 might separate it out from something else.

8 The only additional comment I will make is  
9 to pass along a statement. I am not going to mention the  
10 firm. I don't mean this in a derogatory sense. I think  
11 this is a clear demonstration of the natural logic behind  
12 using a brand name. One of the firms in this country,  
13 what we refer to as a generic supplier, has brought out  
14 promotional material in which it says: "Buy generic and  
15 when you buy generic specify 'X'".

16 Now I would suggest to you that this is in  
17 effect a brand process taking place. It is no longer -  
18 it is a very logical thing because he is attempting to  
19 say I have something about my product which is unique and  
20 in this case the uniqueness ---

21 THE CHAIRMAN: He should have said specify  
22 me instead of specify a name, the name of a product.

23 DR. DIXON: Except that this is still at  
24 this stage of making this a family brand. There are a  
25 number of reasons for this. In this case one of the most  
26 obvious reasons: the line is not that broad. There is  
27 a consistency about the line. It is logical to put one  
28 brand, if you will, on this but as the line spreads and  
29 becomes more complex there is a general pressure towards  
30 proliferation of identifying marks.



1 I think that that is all in general I have  
2 to say but to summarize I would suggest that I can see  
3 there is a pattern or structure in the industry which is  
4 one of competitiveness rather than lack of competitiveness  
5 and that the pattern of profits, prices and other activi-  
6 ties in the industry are therefore to be taken in this  
7 light and I would suggest that this tends to indicate a  
8 reasonableness of performance on these items although I  
9 feel that the structural test is the most significant test  
10 of competitiveness.

11 MR. HUME: Mr. Dixon, just before you answer  
12 questions may I ask you to turn to page 11 of your exhibit  
13 in relation to something that Mr. Whiteley was asking  
14 about yesterday. The method of providing a percentage  
15 profit which I now see there - do I misunderstand this  
16 page? The method of providing a percentage profit for  
17 the years 1953 to 1958 you have shown the profit as a  
18 percentage of net worth as well as a percentage of the  
19 sales dollar?

20 DR. DIXON: Yes.

21 MR. HUME: For industries, including the  
22 pharmaceutical industry - they appear there Mr. Whiteley  
23 on page 11 of that exhibit. A comparison with other indus-  
24 tries from 1953 to 1958.

25 If you turn to page 18 of the brief of the  
26 Association - do you have it with you?

27 DR. DIXON: I think it is in my briefcase as  
28 a matter of fact.

29 MR. HUME: On page 18 there is a net worth  
30 figure of \$57,800,000. You were good enough yesterday to



1 supply me with a figure. I just want to confirm your  
2 calculation. I think that the percentage after taxes,  
3 or take before taxes if that is preferred, in relation to  
4 sales, was 11% before taxes and you worked out the arith-  
5 metic for me and came to 12.3%?

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DR. DIXON: That was after.

2

MR. HUME: That was after taxes?

3

DR. DIXON: I will make this point, it is  
4 not strictly comparable to the percentages that I used,  
5 because as I indicated earlier to the members of the  
6 Commission I also used reserves in my estimate of net sales,  
7 so that a direct comparison onto this wouldn't be possible.

8

MR. HUME: Thank you very much.

9

MR. WHITELEY: Eighteen says surplus and  
10 reserve are included.

11

DR. DIXON: I am sorry.

12

MR. HUME: Perhaps I could give you my  
13 copy.

14

DR. DIXON: It is all right. Then it should  
15 be directly comparable. It would depend what kind of  
16 reserves. The tax department breaks it down in one way.  
17 I don't know which way this report broke it down.

18

MR. HUME: The average on page 11 for the  
19 net worth is 10.1 for a five-year period and net sales at  
20 6.3. For 1960 it is 123 as opposed to 5.5. Are we  
21 talking about the same thing?

22

DR. DIXON: I don't know whether these  
23 figures are strictly comparable.

24

MR. HUME: It would depend on whether ---

25

DR. DIXON: There is some degree of certainty,  
26 they seem to co-relate each other.

27

THE CHAIRMAN: Perhaps we had better break  
28 now. You have had a long period of questioning.

29

30 ---Short recess.



1 THE CHAIRMAN: We will resume the hearing,  
2 ladies and gentlemen. I think Mr. Whiteley has another  
3 few points to ask you.

4 MR. WHITELEY: On the question of risk  
5 and obsolescence, I was wondering if there isn't an off-  
6 set factor in the wide range of products that most of  
7 the pharmaceutical companies produce? In other words  
8 that you may have a fairly rapid shift in some particular  
9 field, but in view of the large number of products these  
10 may effect a mere portion of the company's assets.

11 MR. DIXON: Except, if I may make a comment,  
12 it seems -- there is some indication that the type of  
13 performance of one company may and does, in fact, change  
14 rather significantly with just one of these break-throughs,  
15 so I think this tends to pull it back. Perhaps really risk  
16 is not the word, uncertainty is a better word, the inability  
17 to predict with any degree of accuracy the level of your  
18 sales. I think it is much more difficult in this industry  
19 than in many other industries. I think this is perhaps --  
20 perhaps I should have used a different word. I think risk,  
21 one risk -- perhaps uncertainty would be a better word.  
22 In this connection I don't think the breadth of line is  
23 enough to counterbalance, to really eliminate this as a  
24 factor.

25 MR. WHITELEY: On page 16 you have a table  
26 indicating loss companies and the percentage of total  
27 companies. I was wondering this, in that table, the number  
28 of companies or operators in the particular field might  
29 not be more significant than the rate of profit which is  
30 the basis you have use to select these groups?



1 DR. DIXON: I didn't really use these. The  
2 criterion which I have used to select these ten -- I might  
3 say I didn't go through and compute the rate of profit  
4 for all industrial classifications. What I tried to do  
5 was take a cross-section of different kind of industries,  
6 but which still had a fair amount -- a few of which were  
7 examples of products -- have relatively little product  
8 innovation. A number had quite varying cycle patterns and  
9 so on. I tried to pick, not at random in the sense I  
10 grabbed them out, but to some extent dispersed to give the  
11 picture. I didn't pick them out for their rate of  
12 return because I computed this after I did it. I didn't  
13 do it for any other industry besides these.  
14 There was the time factor. I would have liked to. I wanted  
15 to for my own purposes. The hours on the calculator were  
16 pretty staggering.

17 THE CHAIRMAN: Some conclusions as to the per-  
18 centage loss companies in an industry which has comparably  
19 little innovation compared to the ones with innovations  
20 -- in other words, alcohol has a pretty low average of  
21 loss companies. It might indicate something.

22 DR. DIXON: I think there may well be. This  
23 is not -- I didn't go into it.

24 THE CHAIRMAN: This is an industry of fairly  
25 high innovation and I was wondering if it had any effect?

26 DR. DIXON: I think it certainly is signifi-  
27 cant. If you make a mistake -- you have more potential  
28 mistake situations when you are continually bringing new  
29 products out. Some other industries change their product  
30 less often therefore they are not faced with the possibility



1 that there be a very substantial error.

2 THE CHAIRMAN: Changes are less spectacular,  
3 whatever they may be?

4 DR. DIXON: Yes.

5 MR. WHITELEY: Page 28, table 7, you have  
6 some data on the surveys of city family expenditures.  
7 I am wondering in view of the increased extension of  
8 hospital insurance and the degree to which drugs are pro-  
9 vided as part of that service whether the measure of indivi-  
10 dual family expenditures on prescription drugs is at all  
11 an accurate measure?

12 DR. DIXON: If I could modify that, I think  
13 certainly of today, as of 1960 this would be -- I think  
14 something more sophisticated has to be done, but I think  
15 in 1953 and 1955 when these surveys were performed -- I  
16 don't know, but it seems most of the plans at that time,  
17 the common garden variety plans that most people  
18 participated in excluded payment of drugs. As I recall  
19 my Blue Cross at that time it didn't include, except very  
20 restricted classes of drugs associated with anaesthetics and  
21 things of that order. I don't think at the time of the survey  
22 there would be that much loading or sliding of the  
23 expenditures. I think today it requires a different kind  
24 of investigation. I would suggest the pattern in 1953  
25 and 1955 -- it is unfortunate that this survey, not only  
26 for this purpose, could not be repeated. I think it is  
27 very useful. They are not a recurring normal thing. It  
28 is just a couple they happened to do.

29 MR. WHITELEY: Yes, on page 30 you discuss  
30 this matter of prices to which you referred earlier in your  
testimony.



/dpw

1                   The point made there is, your evidence today  
2 is that the total return on the full product line is the  
3 criterion which should be taken. I am wondering as a  
4 matter of pricing whether that test is really valuable,  
5 if you are not using it here as a sort of look-back  
6 measure rather than a look-forward measure; in other words  
7 how can you possibly anticipate a return from an individual  
8 product as part of your total full line return at a time  
9 when that product is being introduced?

10                   DR. DIXON: I preface this by saying, I  
11 don't envy the particular management group that is respon-  
12 sible for setting these prices. It is a very difficult  
13 process.

14                   I am suggesting that is a process of conti-  
15 nual evaluation, and obviously you will have to set a  
16 price. I would suggest that it would probably be -  
17 and I don't know because I have not inquired into this in  
18 individual companies, but I would presume, and some of  
19 the evidence so far has indicated this, that it would be  
20 priced initially on a close substitute basis. Certain  
21 firms have different pricing philosophies about their  
22 share of the market. It is a function partly based on  
23 the resources they have, and after a short period of time,  
24 the real significance in effect is, one has to look at the  
25 end of each period of investigation, at what the net  
26 return to the company as a whole is, and start looking to  
27 see if something is wrong, and this will tend to cause a  
28 continual readjustment of prices of the product.

29                   MR. WHITELEY: If something is wrong, that  
30 would only be the case if the level of that return is





1 unsatisfactory.

2 DR. DIXON: Not unsatisfactory, but somehow  
3 or other that does indicate to the firm they are not  
4 making as much as they could otherwise.

5 MR. WHITELEY: Yes, you are only looking in  
6 one direction.

7 DR. DIXON: At the top of page 31, really  
8 this behaviour of price can only be checked in the final  
9 sense of a variation in a limited line firm. I am saying  
10 it is almost impossible to make any really significant  
11 comments about the price of one product in a firm that  
12 may have 400 or 500 products. It is just like trying to  
13 determine the validity of the price of one product in a  
14 supermarket, and this problem of leader pricing and every-  
15 thing else becomes very confused. I think that there has  
16 to be in a sense a basic presumption that if the industry  
17 is competitive, there is a process of check on these  
18 prices, and when the industry is not competitive, then  
19 there is not. One can presume in this case in the studies  
20 of the industry, it seems to indicate that the industry is ---

21 THE CHAIRMAN: Your discussion indicated in  
22 your view that the fact that the companies developed new  
23 products will set the price which, as nearly as they can  
24 judge, takes all the factors into consideration and bring  
25 in the best return.

26 DR. DIXON: Yes.

27 THE CHAIRMAN: This in no sense is on a  
28 cost plus a certain percentage basis of determining what  
29 the price is.

30 DR. DIXON: No, and I would suggest that if



1 one were to gather the consensus of busybodies such as  
2 myself, that this would be the sort of pricing pattern  
3 that one would expect in a competitive industry, that  
4 cost in the short run would have no - except in the sense  
5 that it is so obviously bad that you aren't going to go  
6 into it at all, but it would be a demand-oriented price  
7 which implies landing at that spot where the demand for  
8 your product will give you the best possible return.

9 MR. WHITELEY: In assessing the factor of  
10 profits, you point out on pages 38 and 39 that even if  
11 they were substantially moved downward, for example, that  
12 would make relatively little difference in the price paid  
13 by the consumer.

14 I think what we have gathered in the hearings  
15 as far as consumers are concerned is not that it is their  
16 particular view that profits in the industry as a whole  
17 are unreasonable, but that if you view individual items,  
18 you will find really extraordinary differences between  
19 the price at one level of trade and the price at another.  
20 This is really the point that is one of the major concerns  
21 to the members of the public. You have such a difference  
22 between, for example, the sale of one product on a contract  
23 basis to the hospital and the price which the consumer  
24 might have to pay going to a druggist to buy that same  
25 item on a prescription.

26 DR. DIXON: Well I think again without  
27 looking at a specific instance and analyzing it, one cannot  
28 make a specific remark, but certainly there are a host of  
29 factors which do not operate in one circumstance and  
30 operate in the other to cause this price to be substantially



1 different. That is, it becomes a problem of defining  
2 what you mean by "service", but in the sense of the total  
3 distribution services and informational and distributional  
4 service which is provided on the retail level, this is  
5 infinitely beyond the kind of service provided at a  
6 hospital sale, let us say.

7                   One of the things that is required of a  
8 retail sale if one introduces a pharmaceutical, is that  
9 it be rather rapidly available in all outlets. The infor-  
10 mation distributed and so on as opposed to a single  
11 contract on a one-lot basis, and so on would be factors  
12 to be taken into consideration.

13                   I am not saying this is a complete explana-  
14 tion, but there would seem to be a number of factors of  
15 this kind which come in, and it becomes difficult in a  
16 specific case to evaluate this performance. Myself, I  
17 am forced back to my main line of argument in saying is this  
18 taking place       because there is a lack of competitiveness  
19 in the industry, or is it a normal function of the competi-  
20 tiveness which affects the cost and the difference in  
21 selling in these two systems? There is a vast difference.  
22 It is not a phenomena which is unique to the drug industry  
23 at all. This operation and the price this means to the  
24 consumer, these differentials, are very common in many  
25 other industries.

26                   THE CHAIRMAN: They are on that scale? You  
27 could have differences of 30 or 40%?

28                   DR. DIXON: There are differences that will  
29 be higher than that. It depends on the nature of the  
30 distribution process to retail consumers. In some cases



1 it is more complex than in others. The spread upwards on  
2 the retail is perforce greater than the others. The  
3 difference in the manufacturer's selling price I think  
4 has relevance in this circumstance. There are quite a  
5 number of cases where there is a pretty substantial  
6 difference. I don't mean the ratio is exactly the same,  
7 but there is a real gap.

8                   This is not an unusual kind of situation to  
9 occur. Sometimes in some industries it is a matter of  
10 incremental cost. The firm has excess capacity.  
11 Certainly in an industry which is going through technolo-  
2 12 gical changes and continually introducing new products -  
13 I don't know anything about individual firms, but from  
14 time to time there is excess capacity in this industry,  
15 and this kind of pricing to an institution is going to be  
16 necessary.

17                   In other words they are striving to conti-  
18 nue to operate, it is conceivable in some cases. It is  
19 certainly true in some other industries, the auto parts  
20 industry particularly, which I have studied extensively,  
21 that the incremental price is greater and there is not  
22 full cost pricing with them.

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2 DR. DIXON: There practically is a real  
3 argument because the firm is able to price on an incremental  
4 basis, the net price is reduced because of the spreading  
5 of costs. This can be another explanation. As I say, I  
6 have not studied it in any individual firm. This is  
7 certainly true in the auto parts industry where this kind  
8 of differential appeared in many cases.

9 THE CHAIRMAN: Pricing to an institution  
10 on an incremental basis?

11 DR. DIXON: The extent to which you are  
12 dealing with excess capacity; it wouldn't otherwise make  
13 a sale. This enables you to spread fixed costs of the  
14 operation. As I say, I don't know whether this is a  
15 factor in this case or not. One presumes there is some-  
16 thing beyond this. In addition to this, there is some  
17 contribution to the overhead.

18 THE CHAIRMAN: Are there any others with  
19 any questions they would like to ask?

20 MR. FRAWLEY: Yes, I have some, Mr. Chairman.

21 MR. HUME: Mr. Chairman, Dr. Dixon has some  
22 commitments tomorrow in Kingston and if my friends could  
23 so gauge their cross-examination to permit him to finish  
24 tonight; otherwise we are going to have to impose on him  
25 some time at another time. He cannot be here tomorrow.

26 MR. FRAWLEY: This is unfortunate. I defer  
27 to my friend, Mr. MacLeod. I assume, I will say right now,  
28 it is more important that Mr. MacLeod should question the  
29 witness than that I should. I have some questions that I  
30 would like to put to him. I accept Mr. Hume's suggestion





1 that we wouldn't wish to keep him from his classes tomorrow,  
2 but perhaps Dr. Dixon could come back next week.

3 THE CHAIRMAN: You may be quite a while?

4 MR. FRAWLEY: You never can tell. Sometimes  
5 one starts out with a simple question, and it becomes  
6 somewhat argumentative. Now, particularly because I am  
7 very humble, I am proposing to ask some questions of a  
8 professor of economics, and I always approach those tasks  
9 with great trepidation, although the manner and style of  
10 the witness commends itself to me very much, but still we  
11 might get into a lot of discussion. In the interests of  
12 the main cause, perhaps Mr. MacLeod --

13 MR. HUME: I would like to say, Mr. Chairman,  
14 I do not expect you to rule in advance, but I would say  
15 this to my friend Mr. Frawley so that he may be advised  
16 if he starts into a general line of questions about prices  
17 per se, I am going to object to every question that is  
18 not within the terms of reference which you have enunciated  
19 so clearly that this Commission is not interested in whether  
20 a price of a particular product is high as such.

21 In that context I am going to try to keep  
22 my friend's examination within the bounds of this reference.

23 THE CHAIRMAN: I think in view of the fact  
24 we would like to clear Dr. Dixon this afternoon, if possible,  
25 we will try to keep our questions relevant to the issues  
26 before us. It is always possible a question within itself  
27 may seem not to be directly relevant, but may show to be  
28 relevant because of other material relevant to the issues  
29 before us under our Statute.

30 Usually, as a matter of simplicity in handling



1 questions, we have had Mr. MacLeod come on at the end  
2 when everybody else has asked all the questions they have  
3 in mind.

4 MR. FRAWLEY: I think I should make this  
5 clear; I certainly defer to my friend, Mr. MacLeod, but  
6 I do have a few questions to put, and I am sure that neither  
7 my friend Mr. Hume nor the witness wants to so completely  
8 defeat me that I won't be allowed to ask them at all.  
9 If Mr. MacLeod should go through to the time when you want  
10 to adjourn, I would ask my friend Mr. Hume to be good  
11 enough to bring Dr. Dixon back next week.

12 THE CHAIRMAN: Do you anticipate taking a  
13 great deal of time, Mr. MacLeod?

14 MR. MacLEOD: I am somewhat in the same  
15 position as Mr. Frawley. I am not quite sure, depending  
16 on just how it develops. I would not anticipate taking too  
17 long.

18 THE CHAIRMAN: It is now five minutes to four.  
19 With both of you examining, we would have difficulty in  
20 concluding by four-thirty or quarter to five.

21 MR. MacLEOD: I think I might take that  
22 time myself. Half an hour.

23 THE CHAIRMAN: What would be the difficulties  
24 of getting Dr. Dixon back next week?

25 DR. DIXON: Very difficult in the beginning  
26 of the week at least. It creates an immense problem at  
27 this time.

28 THE CHAIRMAN: We are ourselves occupied I  
29 think on Monday and Tuesday.

30 DR. DIXON: Tuesday is of the three days the



1 easiest one for me.

2 THE CHAIRMAN: Probably fit it in sometime.

3 DR. DIXON: If you could possibly -- the  
4 prospect of just coming down Tuesday afternoon and then  
5 going right back again, I wouldn't even have to miss any  
6 classes.

7 MR. FRAWLEY: I think perhaps Mr. MacLeod  
8 had better go ahead.

9 THE CHAIRMAN: I think that might be better.  
10 You may decide not to ask too many questions.

11 MR. HUME: No such luck.

12 MR. FRAWLEY: I am not acting for the Attorney  
13 General of Canada.

14 MR. MacLEOD: Do you know Professor A. E.  
15 Kahn? I believe he is Professor of Economics at Cornell.

16 DR. DIXON: I am acquainted with him to some  
17 extent.

18 MR. MacLEOD: Is he a recognized economist?

19 DR. DIXON: I will say this: I cannot give  
20 you any titles at the moment. I have seen the name,  
21 certainly more than once.

22 MR. MacLEOD: Is the American Economic  
23 Review a recognized journal in the field?

24 DR. DIXON: No question about that.

25 MR. MacLEOD: I am going to read a passage  
26 here by Professor Kahn, and I am going to ask your opinion  
27 on it. I think perhaps you have expressed the same opinion  
28 yourself a few moments ago. This is in a symposium dealing  
29 with the pricing objectives in large companies.

30 The passage I am going to read appears on



1 page 674 of the September 1959 issue of the Journal, or a  
2 review of it, and this is what he said:

3 "4. In many situations, target-return pricing  
4 simply does not make sense except as an  
5 ex post rationalization of profit-maximiza-  
6 tion. Explications of the method by  
7 company officials tend irresistibly to proffer  
8 "good" rather than "real" reasons -- although  
9 considerations of fairness, or defensibility  
10 before Congressional investigating committees  
11 (or against wage demands) undoubtedly play  
12 some role in pricing decisions, in some  
13 companies more than others.

14 For example, the policy sometimes pro-  
15 claimed by du Pont officials of determining  
16 the prices of new products with reference  
17 to the research and developmental expenses  
18 they have involved would actually be an  
19 irrational means of recouping those expenses.  
20 Here is the company's avowed explanation:

21 'If our contribution of an improved new  
22 product is an exceptional achievement because  
23 of long and expensive research and development  
24 and a high permanent investment hazard, and  
25 if it affords profitable opportunities to  
26 consumers or converters, we feel we are  
27 entitled to an exceptionally good return  
28 and we ask a corresponding price for it. If  
29 our contribution has been only a moderate  
30 one, then we determine upon a price that will



1 give us a profit consistent with our work,  
2 effort, and risk (5,p.153).'

3 "The statement is equivocal, yet clearly,  
4 among other things, it implies that the  
5 "value of the contribution" that helps determine  
6 price is determined in large measure by its  
7 cost, including the risks it has entailed.  
8 But it makes no sense to try to recoup research  
9 costs by charging a cost-based price that  
10 either exceeds or falls short of the profit-  
11 maximizing level. Sunk costs may be used  
12 to JUSTIFY a price embodying a high mark-up  
13 over out-of-pocket expenses, for public  
14 relations purposes; but it cannot EXPLAIN  
15 it, unless the responsible officials have  
16 thrown rationality to the winds. The only  
17 connection in which they might intelligently  
18 relate price to sunk costs ex ante would be  
19 if they REDUCED or voluntarily accepted less  
20 than the profit-maximizing price that threatened  
21 to recoup too much (by standards of  
22 reasonableness or whatever) -- never if they  
23 increased or exceeded a profit-maximizing  
24 price that threatened to recoup too little.  
25 So, references to heavy research and  
26 developmental expenses are not convincing  
27 as explanations of high prices and profit  
28 margins; and that is what they are usually  
29 adduced to explain."

30 -





TJ/MR/dpw 1

DR. DIXON: Would you like me to comment on

2 that?

3 MR. MACLEOD: Yes.

4 DR. DIXON: I would break it out in two  
5 ways: I would take issue with the last statement as a  
6 complete statement in the sense that if, in fact, this is  
7 one of the costs of operating, that a firm has to anticipate  
8 that if in its pricing process it doesn't have its price  
9 high enough to cover the cost it won't stay around, but I  
10 - in other words over time the firm has to consider this  
11 but I would agree that in the short run the significant  
12 issue has to be a demand-oriented price. But the firm,  
13 still, I think, has to be aware of the fact that this is  
14 a type of expense which it has and if it doesn't - in  
15 other words, what I said before, in the long run price  
16 must have a relationship to cost. You can't operate  
17 without reference to it.

18 THE CHAIRMAN: Doesn't that mean that if  
19 it can't get it back from the one product, full cost it  
20 has incurred, they must get it from some other products?

21 DR. DIXON: That is what I mean by this  
22 full line pricing. They either do or go out of business.  
23 If they can't get it somewhere else, I would suggest this  
24 implies ---

25 THE CHAIRMAN: Then they are in trouble.

26 MR. MACLEOD: You made some comment on the  
27 use of trade names. Have you considered the objections  
28 to the use of trade names allegedly made by Dr. Walter  
29 Modell and introduced on page 23 of the statement?

30 DR. DIXON: Page 23 of the Green Book?



1 MR. MACLEOD: Yes. He says, I will read  
2 one particular passage of it: "Using trade names that  
3 give no idea of the content of the drug or what clinical  
4 family it is in, is not only confusing, but dangerous..."  
5 This will be a different aspect than you perhaps...

6 DR. DIXON: I would suggest that nobody -  
7 that I see nothing in the industry that indicates that  
8 in fact the industry uses the trade name without reference  
9 to what is in it while it is communicating or trying to  
10 sell its product to the - or at least convincing the prac-  
11 titioner of its merit.

12 I would suggest that using a trade name  
13 without - giving no idea of the contents under certain  
14 circumstances is an awfully smart thing to do. For  
15 instance, writing out a prescription.

16 MR. HUME: I think perhaps in fairness Mr.  
17 MacLeod should tell the witness that what he just read  
18 would be illegal in Canada. You have got to show the  
19 composition.

20 DR. DIXON: Yes, I think - I can't conceive  
21 of a circumstance in which a firm in fact does buy some-  
22 thing or other without - or if they did, certainly I  
23 cannot see the medical profession accepting this. I  
24 don't think that statement is ---

25 MR. MACLEOD: The doctor continues: "The  
26 confusion of using proprietary names has made it possible  
27 in a discussion between two specialists in the same field  
28 for neither to know that each is talking about the same  
29 drug". If that actually happens, then of course there  
30 definitely is confusion, isn't there?



1 DR. DIXON: I would suggest that this is  
2 probably - I don't know because this is - we are getting  
3 into not a matter of branding per se, which is a marketing  
4 phenomenon - into medical usage, but I would think that  
5 this is what some of the reporting services would do,  
6 would list - I don't know about specialists, but certainly  
7 I myself while in no way a specialist am familiar with a  
8 number of drug substitutes under different brand names  
9 because I happened to have received them.

10 I don't know, obviously, if this situation  
11 does exist but I can see nothing - whether it exists or  
12 not I would suggest it indicates something about the -  
13 that the profession itself has some problems on its hands  
14 with communication if this is the case.

15 MR. MACLEOD: The only reason I brought it  
16 up was that I think it indicates that in this field there  
17 are wider considerations than the ones you made this  
18 morning and they would have to be considered as well as  
19 the ones that you did point out.

20 DR. DIXON: All I am suggesting from the  
21 point of view of the firms is that it is logical under  
22 circumstances that we find in this industry, generally  
23 speaking, to use trade names. If in other segments of  
24 the industry which I referred to, which were a market  
25 test on promotional activity, if in fact the market  
26 doesn't want it, it wouldn't have it. You would have  
27 everybody following Dr. Modell's suggestion and the firm  
28 clearly couldn't do it. I don't see any evidence of this  
29 happening in significant enough degree to warrant this  
30 kind of a conclusion.



1 MR. MACLEOD: Have you read the second  
2 paragraph on page 289 of the Statement?

3 DR. DIXON: At one stage - I'd better read  
4 it. The second paragraph?

5 MR. MACLEOD: Well it's "a minimum and abso-  
6 lute requirement.."

7 DR. DIXON: Oh yes. What about it?

8 MR. MACLEOD: Well that would indicate  
9 that this situation does arise apparently because in this  
10 particular case tablets were ordered by number. Some  
11 manufacturers use a number instead of a trade name but  
12 it is a registered trade name.

13 DR. DIXON: All I can say is ---

14 MR. HUME: I think that is a matter of  
15 argument. I suggest to have the witness read a section  
16 of a paragraph - you might ask him a question about it  
17 but not argue with him about it.

18 MR. MACLEOD: The witness said to me that  
19 he had no evidence of this happening. I just suggested  
20 to him it might.

21 DR. DIXON: No, I said - I didn't say that.  
22 I said that I saw no evidence that there was a demand in  
23 the medical profession as evidenced by a substantial list  
24 to non-trade name use that indicated that the profession  
25 as a whole, that the market was communicating that some-  
26 thing should change. This is what I said. I didn't say  
27 that confusion did not occur.

28 MR. MACLEOD: The simple point I want to  
29 make: there might be other factors influencing the desira-  
30 bility of using trade names in the drug field which would



1 not apply to automobiles or electric appliances or things  
2 of that nature.

3 DR. DIXON: I will only make one remark  
4 because I am not in any sense a pharmacologist but I  
5 would suggest that the information to which this quote  
6 refers as indicating the physician did not know - if I  
7 were a patient and I found this out about my physician,  
8 I would be very disturbed.

9 MR. MACLEOD: You would be dead.

10 DR. DIXON: All right then, my wife would be  
11 very disturbed and it seems to me this information is in  
12 fact available. This is getting - this seems to me -  
13 again I am not a technical expert but this seems to me  
14 to be a matter of professional performance, not a matter  
15 of industrial performance that is involved here. There  
16 may be some people who would be better qualified than  
17 myself on this.

18 MR. MACLEOD: Yes. I don't want to extend  
19 the discussion.

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1 MR. MACLEOD: Now, the compilations which  
2 you made in your exhibit were based on the firms listed  
3 by D.B.S. as being members of this industry, were they?

4 DR. DIXON: The data I used, it came from  
5 two sources. It is part of the confusion, the difficulty  
6 of getting data that I mentioned in the earlier part of  
7 the exhibit in my attempt to justify using not strictly  
8 identical information. This was simply that the informa-  
9 tion on sales and profits came from the taxation statis-  
10 tics under the listing of pharmaceutical preparation  
11 industries. The information on concentration came from the  
12 D.B.S. report on medicinal and pharmaceutical preparation  
13 industries. It is not strictly comparable. The number  
14 of firms are different. The two bodies didn't completely  
15 agree, apparently, on their listings, but I felt indications  
16 were that they were comparable enough to use.

17 MR. MACLEOD: Yes, but there is quite a  
18 variety in the type of firms used, the operations carried  
19 on by the respective firms.

20 DR. DIXON: Which particular - what industry?

21 MR. MACLEOD: Take D.B.S., for instance.

22 DR. DIXON: Yes.

23 MR. MACLEOD: You have veterinary firms,  
24 firms selling shaving cream and shampoo, and toothpaste  
25 as part of their lines, proprietaries of various kinds.

26 DR. DIXON: This is not true of the material  
27 in taxation statistics which divides toiletries and cosme-  
28 tics and products of this kind from pharmaceutical prepara-  
29 tions.

30 MR. MACLEOD: Does it separate...



1 DR. DIXON: Proprietaries?

2 MR. MACLEOD: Does it separate proprietary  
3 drugs from ethical drugs?

4 DR. DIXON: I don't believe it does. From  
5 what I gather the preparations in this title certainly  
6 do not make up the major part of the total.

7 MR. MACLEOD: Which doesn't?

8 DR. DIXON: The proprietaries and also some  
9 of the - some of the proprietary products wouldn't be  
10 included in the taxation statistics because as also has  
11 happened they will be included in other industrial classi-  
12 fications which are part of another line, the food line  
13 or something of this order. It is a little difficult to  
14 nail it down precisely, but it is fair - particularly  
15 since it tends to co-relate with some of the data which  
16 has been covered by the industry itself. Some of the  
17 figures seem to tie in fairly well in terms of net profit  
18 on sales.

19 MR. MACLEOD: Yes. You said a moment ago  
20 it was typical of the proprietary firms to be in some  
21 other field as well.

22 DR. DIXON: I said it seems to be more  
23 typical, perhaps, than the ethical firms. That is all I  
24 said. I didn't mean they all were.

25 MR. MACLEOD: Your figures would be based  
26 to a substantial extent on sales of proprietary products  
27 and sales of veterinary products, of necessity, because  
28 these firms were included by D.B.S.?

29 DR. DIXON: D.B.S. show non-human pharma-  
30 ceuticals make up a very small proportion of the sales of



1 these companies.

2 MR. MACLEOD: Non-human, that would be veterinary?

3 DR. DIXON: Yes, and also proprietary medicine is a  
4 relatively small classification. I am sorry, I don't have  
5 the book in front of me. I don't have the latest table.  
6 They break it down in the beginning of the report each  
7 year. I think I make a reference to this somewhere as to  
8 the percentages, but to be rather specific, the majority of  
9 the sales that D.B.S. show of the firms is in the field of  
10 human pharmaceuticals.

11 MR. MACLEOD: Of course, you run into the difficulty  
12 there as to where you draw the line. For instance in the  
13 Compendium of Pharmaceutical Specialties, Frosst A.S.A.  
14 products would be included. Bayers Aspirin wouldn't and  
15 neither would Anacin. Apparently the author of this book  
16 feels that Frosst's production is a specialty and the other  
17 is patent medicine.

18 DR. DIXON: There is always going to be  
19 a definition problem.

20 MR. MACLEOD: I was just leading up to the  
21 point of asking you to express an opinion on the compara-  
22 bility of the firms. Isn't it true that the products are  
23 not homogenous, while they are in the same area they  
24 don't sell comparable products?

25 DR. DIXON: I think certainly a substantial  
26 amount of them - not I think, I know, a substantial  
27 amount do. The product lines overlap in some cases, but  
28 certainly the only - the firms that I have seen, specifi-  
29 cally looked at, certainly produce lines - substantial  
30 numbers of them are pretty broad. For instance the firms



1 within the Association whose sales are rather a substantial  
2 part of the total D.B.S. figures, certainly there are  
3 large numbers of firms which have a broad line that compete  
4 and is to some degree comparable.

5 MR. MACLEOD: Yes, but there are areas in  
6 which certain firms have specialties?

7 DR. DIXON: Not used by all the firms in  
8 the industry, yes, that is true.

9 MR. MACLEOD: Until the compulsory licence  
10 is issued, for instance, chloramphenicol was exclusive  
11 with Parke-Davis.

12 DR. DIXON: I don't know.

13 MR. MACLEOD: I wanted to ask you about the  
14 failure rate. Can you indicate whether those failures  
15 were among large companies or among smaller companies?

16 DR. DIXON: I can't say whether there were,  
17 in fact, except in one or two cases which can be obser-  
18 vable from published statements. There have been large  
19 companies involved. There tends to be a larger proportion  
20 of small companies. I think this is just by the prices  
21 and sales involved.

22 MR. MACLEOD: Yes.

23 DR. DIXON: But there is no way...

24 MR. WHITELEY: Are you referring to Table 4?

25 MR. HANSARD: I don't understand the word  
26 "failure".

27 DR. DIXON: Loss you meant rather than  
28 failure.

29 MR. HUME: You were speaking as if he asked  
30 loss.



1 MR. MACLEOD: Were there, in fact, any  
2 failures that came to your attention?

3 DR. DIXON: There have been some. The  
4 failure rate has not been, in the period I studied it,  
5 very high, nor would I in any sense expect the absolute  
6 failure rate to be high when the industry is growing as  
7 rapidly as it is because of the possibility for increased  
8 sales.

9 MR. MACLEOD: Doesn't the industry, in fact,  
10 have a reputation for stability, that firms operate in it  
11 for many years?

12 DR. DIXON: The only answer I could give  
13 to that, I don't think anything that is said about the  
14 industry prior to 1945 has any relevance to the industry  
15 today. I would suggest, I think, as I indicated before,  
16 ten years from now it might be a far different story.

17 MR. MACLEOD: I know, for instance, that  
18 Parke-Davis boast an unbroken dividend stretching back  
19 to 1879. That is reported in Barrons of May 29th, 1961.  
20 Wouldn't one of the large companies in the particular field  
21 claiming dividends continuously for almost 100 years indicate  
22 a relatively stable business?

23 DR. DIXON: All it would indicate is this  
24 firm was consistently successful in doing its job.  
25 Beyond that you can't say anything. This would be an impor-  
26 tant factor why the firm has been in existence since that  
27 period.

2 28 MR. MACLEOD: If we find the same experience  
29 with respect to other principal firms would you say that  
30 would be an indication that the industry is stable?





1 DR. DIXON: As I say I think there is indi-  
2 cation that in years past this has been a characteristic  
3 of the industry. I don't think it is relevant to the  
4 circumstances I see right now. I think that is all I  
5 could say without going a way off into the realm of conjec-  
6 ture.

7 MR. MACLEOD: So whatever has been the  
8 situation in the past it may not be true now and it may  
9 not be the situation in the future?

10 DR. DIXON: I suspect it is less likely to  
11 be true later. I think this makes it more difficult to  
12 study the industry now because it is in a state of flux.

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1 MR. MacLEOD: Do you think that the com-  
2 petition which exists in the industry is effective as a  
3 factor in influencing price?

4 DR. DIXON: I can see no other indication  
5 but that if given this main presumption or main indication  
6 that product development is crucial to the success that  
7 this is going to mean that the inferior agents as they  
8 are replaced by superior agents will certainly suffer or  
9 will tend to be forced down in price. I don't by any  
10 stretch of the imagination believe that price is the  
11 significant, the only, or the primarily competitive weapon  
12 in this industry, as I think I have indicated.

13 MR. MacLEOD: Yes, and from the information  
14 set out in Green Book, it will appear that there are two  
15 distinct situations, one being exemplified by the old  
16 penicillin where price competition has been intense, and  
17 prices have fallen and continue to fall. When we have that  
18 situation, and the other exemplified by a drug like  
19 chloramphenicol which remained at the same price for  
20 approximately ten years, from 1951 until late 1960 -- I am  
21 sorry, I should say for ten years in the United States --  
22 In Canada there was no adjustment made reflecting the  
23 1951 reduction. That didn't come until 1953. But from  
24 1953 and from 1960 the price was absolutely the same.

25 MR. HUME: Is there a question, or is that  
26 a statement of fact, Mr. MacLeod? Have you got a question  
27 for the witness?

28 MR. MacLEOD: Does that indicate that in  
29 respect of the two products I have mentioned, that price  
30 competition is working in respect of one but price competition



1 is not the factor in respect of the price of the other?

2 DR. DIXON: I don't think I would agree in  
3 the sense of black and white, that it is in one and is not  
4 in the other. I think throughout this period one thing that  
5 has happened has been a pretty substantial change in the  
6 pattern of operating costs in the industry and in prices  
7 in general, and to this extent, I would suggest that there  
8 has been some pressure somewhere to keep these prices  
9 from moving upward.

10 I would agree that in some products the  
11 importance of the non-price factors are more significant  
12 than the price factors, because it is the performance  
13 factor in new or different or special purpose products that  
14 the market is looking for.

15 Now with products that are staples, if you  
16 will, the performance is taken as read; that is, the  
17 performance is essentially the same in all products. This  
18 may be a little too sweeping.

19 MR. MacLEOD: Yes.

20 DR. DIXON: But the market is looking to the  
21 new product for in fact the performance, and the competition  
22 is coming.

23 Before I make any comment on the amount of  
24 competition, I would like to have an indication of the  
25 sales volume on this product and similar therapeutic agents  
26 throughout the period of time, and then I will be able to  
27 tell you more. Under the circumstances themselves, I  
28 would be able to tell you more. It would assume some  
29 relevance.

30 MR. WHITELEY: Your suggestion was the period



1 of ten years in the present state of the industry was a  
2 relatively long period; therefore, if a price of a product  
3 remained unchanged throughout that period, it would be a  
4 relatively long time?

5 DR. DIXON: Yes.

6 MR. WHITELEY: So would you view the one  
7 where the price came down fairly rapidly as being one in  
8 which price competition came to bear directly on the  
9 product?

10 DR. DIXON: In the other one?

11 MR. WHITELEY: And in the other the price  
12 competition did not come to bear directly on the product.

13 MR. HANSARD: Isn't there a factor that  
14 has not been put to the witness about the case of penicillin.  
15 We all know the record is there was a vast overproduction  
16 of penicillin, and that is the factor that would bear on  
17 the price coming down rapidly. People got out of that  
18 business. We found that out.

19 MR. WHITELEY: The witness would not suggest  
20 that sort of price competition becomes very effective. Is  
21 that not the case?

22 DR. DIXON: If you have a standardized  
23 product, that is the result; I think I would agree that  
24 non-price competition is more important in those products,  
25 and I would suggest that non-price competition is more  
26 effective in the industry as a whole. I think that is  
27 more apparent.

28 MR. MacLEOD: There is a reference on page  
29 57 in the Green Book under "Companies and Products", Parke  
30 Davis Antibiotics which has chlormycetin introduced in 1949.



1 It resold in increased sales of 86% and a jump in Pre-Tax  
2 net of 220%.

3 MR. HUME: That is on the bottom line of  
4 the table.

5 DR. DIXON: Yes.

6 MR. MacLEOD: That was the experience of  
7 the company on the introduction. Again going to page 22  
8 of Baron's dated May 29, 1961, may I just read this:

9 "Founded 95 years ago, ---- lower than  
10 eighty million dollars".

11 In the case of the company that we are talking about, this  
12 drug was introduced in 1949 and apparently made a sub-  
13 stantial contribution to the profit of the company at that  
14 time, and yet the detailed figures given in the Green Book  
15 show it is obviously still quite a profitable line to the  
16 company, but yet for ten years it has not changed in price.  
17 Surely it is pretty well insulated from the forces that  
18 affect this, isn't it? It must be.

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/EMT/hm 1 DR. DIXON: Well, except when you use the  
2 word "insulate". I have been bothered -- not just in this,  
3 but in a lot of other cases -- if the main pressure from  
4 the market is for non-price, if the factors of quality or  
5 product performance are indeed the factors the market is  
6 looking for, and I suggest this is what the market is  
7 looking for, then there is not going to be the kind of  
8 pressure in some cases.

9 I don't know about the pharmaceutical  
10 industry, what kind of sales volumes there are, and I  
11 can't tell because I cannot compare those as to which are  
12 close. I think the word "insulate" -- I would expect this  
13 main pressure to come from the other direction. It is  
14 typical of many other industries in our economy today.  
15 Product performance is the test that the market looks at.  
16 The automobile industry has certainly been characterized  
17 by this.

18 MR. MacLEOD: Yes.

19 DR. DIXON: The appliance industry is  
20 changing its character and may be coming back to it, but  
21 I don't know.

22 MR. MacLEOD: In any event, the forces that  
23 are operating ---

24 DR. DIXON: Are more in the area of non-  
25 price than price.

26 MR. MacLEOD: There apparently is no push  
27 afoot to bring the selling price of this product close to  
28 its cost of production.

29 DR. DIXON: I can't answer that. I don't  
30 know what its cost of production is. I can't make a



1 statement under the circumstances. I don't know what the  
2 facts are. It is entirely possible. Certainly it is  
3 also possible that the reverse is true. It is clearly  
4 contributing to the profit of the company. How much above  
5 cost, I don't know.

6 MR. MacLEOD: The details are set out in  
7 the green book, and I think using rough figures I could  
8 say that the cost, what would cost approximately \$100.00  
9 to manufacture and prepare and bottle and everything else, to  
10 sell for somewhere in the order of \$1,000.00 to \$1,200.00.

11 DR. DIXON: At retail?

12 MR. MacLEOD: No, that is what the manu-  
13 facturer would sell it for. Retail, it would sell for  
14 something like \$2,500.00.

15 MR. HANSARD: Where are the figures?

16 MR. HUME: Which pages are these shown in  
17 the green book, Mr. MacLeod?

18 DR. DIXON: Again this gets back to the  
19 problem which has been raised many times. This is the  
20 cost of manufacture; this is not the cost of the product.

21 MR. HUME: I think what the witness, Mr.  
22 Chairman, is entitled to know in answering that question  
23 is what went into the making up of the hundred dollars.

24 MR. WHITELEY: I think the witness is pre-  
25 pared to state if this one product provided a large part  
26 of the additional income of the company, clearly it must  
27 have been selling the finished product above cost to pro-  
28 vide that profit.

29 MR. HANSARD: Surely we should hear from  
30 Mr. MacLeod. He has produced some very startling figures.



1 MR. FRAWLEY: I would like to make this  
2 observation ---

3 THE CHAIRMAN: Order. Let's see if we can  
4 get this one item cleared, please.

5 MR. MacLEOD: I stated that my figures are  
6 approximate, and were based on these ---

7 THE CHAIRMAN: What page?

8 MR. MacLEOD: Page 168. There is a state-  
9 ment the cost of chloramphenicol is \$90.00 per kg. It  
10 is paragraph 284.

11 THE CHAIRMAN: Bottom of page 168.

12 DR. DIXON: Actually I think we are talking  
13 in terms of selling price by Fine Chemicals of \$200.00 per  
14 kg.

15 MR. MacLEOD: No, we are talking about  
16 Parke-Davis.

17 DR. DIXON: This is in the same line.

18 MR. MacLEOD: Excuse me. Fine Chemicals  
19 were simply selling the bulk to other manufacturers who  
20 then prepared the dosage forms.

21 DR. DIXON: What I am suggesting is that  
22 there may be a relationship between this \$90.00 and this  
23 \$200.00 in the sense that we are trying to get at reported  
24 cost of manufacture of a bulk product. Then when you add  
25 the cost of -- I am trying to lead up -- add the cost of  
26 getting it ready for distribution, distributing it,  
27 promoting it, this brings the price up to \$200.00, and then  
28 it sells -- what are those prices, "Atlantic Trading Company  
29 reported that prices during 1959 ranged from \$60.00 to  
30 \$250.00 per kg."? What prices are these they are referring



1 to?

2 MR. MacLEOD: Those are prices of raw  
3 material in Europe, comparable to cost price of ---

4 MR. HUME: I am so thoroughly confused I  
5 propose, Mr. Chairman, to see if I can straighten this out.  
6 I understand that \$90.00 in section 284 is the hundred  
7 dollars to which you referred earlier; is that correct,  
8 Mr. MacLeod?

9 MR. MacLEOD: Yes.

10 MR. HUME: Your estimate was \$100.00, and  
11 it turns out your figure is \$90.00?

12 MR. MacLEOD: No, I am estimating the  
13 balance as being the cost of preparing dosage forms.

14 MR. HUME: The two figures I heard were  
15 \$100.00 and \$1,200.00. Can you explain to me what you  
16 mean by the hundred dollars?

17 MR. MacLEOD: The hundred dollars would be  
18 approximate cost of Parke-Davis preparing 1 kg of  
19 chloromycetin in packaged form, ready for sale over the  
20 counter.

21 DR. DIXON: I am sorry, sir, I have only  
22 been inside two pharmaceutical houses, but if the \$90.00  
23 and this \$200.00 Fine Chemicals' selling price on the basis  
24 of raw materials have some indication this \$90.00 figure is  
25 for physical cost of manufacturing the product in its bulk  
26 form, I would suggest there is every possibility that the  
27 dosage form costs could be many times that. I don't know.  
28 I am moving into an area where I have absolutely no  
29 confidence because I don't know anything about the produc-  
30 tions costs. Not from two hour observations.



1 MR. MacLEOD: They may not be accurate  
2 figures on the cost of the dosage forms in Canada but in  
3 the case of Upjohn in the United States, it costs 41 cents,  
4 and in the case of Bristol it costs 41 cents to prepare  
5 100 capsules.

6 DR. DIXON: Of what?

7 MR. MacLEOD: Of Tetracycline, which is a  
8 comparable drug, and as the only operation involved is  
9 capsuling and packaging and labelling, I think we can assume ---

10 MR. HUME: Are we off the Parke-Davis thing  
11 now? Are we off it now? I am sorry, Mr. MacLeod, and Mr.  
12 Chairman, with your permission, it still has not been made  
13 clear to me what the point of the question was between the  
14 figures \$100.00 and \$1,200.00.

15 MR. MacLEOD: \$93.00 is the cost of the basic  
16 drug.

17 MR. HUME: That is raw material as it leaves  
18 the manufacturer of the raw material.

19 THE CHAIRMAN: Where is that?

20 MR. HUME: Where is that \$93.00?

21 THE CHAIRMAN: It is \$90.00. You see  
22 "Reported cost of manufacture is of the order of \$90.00  
23 per kg".

24 MR. MacLEOD: Yes.

25 THE CHAIRMAN: Does that mean in bulk form  
26 or in packaged and dosage form?

27 MR. MacLEOD: That is in bulk form.

28 THE CHAIRMAN: \$90.00. Fine Chemicals  
29 apparently sell at \$200.00 after paying royalties.

30 MR. MacLEOD: That is correct.





1 THE CHAIRMAN: But the same thing.

2 MR. MacLEOD: Parke-Davis don't sell the  
3 drug in bulk. They refused to sell it to anybody.

4 DR. DIXON: The difference obviously includes  
5 cost of putting it in some form of package and selling it  
6 and distributing it.

7 MR. MacLEOD: Perhaps this will explain it.  
8 For a long time Parke-Davis was the only manufacturer of  
9 chloramphenicol in Canada, and it refused to supply the  
10 basic drug to any other pharmacist.

11 MR. HUME: Is that a statement of fact?

12 MR. MacLEOD: That is a statement of fact,  
13 yes. Fine Chemicals obtained a compulsory licence to  
14 manufacture chloramphenicol. They have since started  
15 manufacturing, and their costs are as reported there. Fine  
16 Chemicals doesn't sell to the -- at least in respect to  
17 this product -- does not sell to the drug store or to the  
18 drug trade at all. It sells to Intra Drug and it sells  
19 to Frank W. Horner, this particular product. Both Intra  
20 Drug and Frank W. Horner will sell that chloramphenicol  
21 to the public in dosage form.

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ipw

1 The price of \$200 is simply to go to  
2 another source. Parke-Davis would be manufacturing it  
3 for \$90. Anyone else who can make the necessary arrange-  
4 ment can get it for \$200.

5 MR. HUME: Would you agree, Mr. MacLeod,  
6 that the \$200 would include some ingredients not in the  
7 \$90? For example, the job of packaging and selling it  
8 to the customer which Parke-Davis doesn't have. Transpor-  
9 tation.

10 MR. MACLEOD: Except that I would assume  
11 that the cost of packaging a bulk drug would be very  
12 small.

13 MR. HUME: Do you agree that there is some-  
14 thing there that is not in the Parke-Davis product? That  
15 is all I want for my present purpose, that you are not  
16 comparing dark with light.

17 MR. MACLEOD: I am not comparing the two  
18 at all. What I am comparing is as to the cost of the  
19 drug and the preparation, which I presume to be something  
20 over \$100 based on this, that it costs \$90 for the drug  
21 itself.

22 THE CHAIRMAN: That is the cost of Parke-  
23 Davis or the cost of Fine Chemicals or do you assume the  
24 cost is the same?

25 MR. MACLEOD: I have the exact costs from  
26 those firms and they are very close to each other.

27 THE CHAIRMAN: This means that Fine Chemi-  
28 cals can manufacture chloramphenicol at about \$90 per  
29 kilogram and that they sell it at \$200?

30 MR. MACLEOD: That is right. That has



1 nothing to do with my present point. My present point  
2 was this: taking the basic cost of \$90 based on informa-  
3 tion of detailed tables admitted to be correct by the  
4 companies themselves, published in the Kefauver Report,  
5 operating costs somewhere in the order of perhaps \$15 -  
6 \$16 to prepare this product in dosage form, prepare one  
7 kilogram so that I estimate the total cost, the total  
8 direct cost of preparing the dosage forms ready for resale  
9 would be something slightly above \$100.

10 MR. HANSARD: This Kefauver information that  
11 you have Mr. MacLeod, that was for the comparable product,  
12 not the same product?

13 MR. MACLEOD: Not the same product; for the  
14 comparable product.

15 MR. HANSARD: Are you assuming that they  
16 are comparable, or do you know?

17 MR. MACLEOD: I am assuming that the cost  
18 would be of the same order.

19 MR. CONDER: And the same in Canada as in  
20 the United States on the cost of manufacturing this pro-  
21 duct, or putting it into dosage form?

22 THE CHAIRMAN: We are getting a little bit  
23 confused. One is talking about manufacture and the other  
24 is talking about packaging. They are not the same thing.  
25 Manufacturing involves a good deal more than packaging.  
26 I would think that the cost of merely packaging would be  
27 a lot less than manufacturing the process and the cost of  
28 putting things in capsules and putting them into bottles  
29 and boxes would not vary tremendously, if it is done in  
30 something like the same quantity.



1 MR. R.C. PAYTON: The only reason I am on  
2 my feet is having at one time acted for Fine Chemicals  
3 and having been many times in their plant, it astounds me  
4 that my friend Mr. MacLeod seems to have an intimate  
5 knowledge, or if I may say, a lack of intimate knowledge  
6 of their processes which he is putting forward as accurate  
7 information.

8 I feel that the statement that he is making  
9 is most misleading. I question whether he can accurately  
10 inform you as to whether it is a packaging operation or a  
11 manufacturing operation or just exactly what the operation  
12 is.

13 Unless he can, I suggest that the statement  
14 should not be permitted.

15 MR. FRAWLEY: Of course, the obvious solu-  
16 tion is that Parke-Davis should be here telling us all  
17 about what it costs to manufacture and to package.

18 THE CHAIRMAN: Some difficulty, of course,  
19 in getting data about particular company's operation and  
20 these companies are not here. It may be that Mr. MacLeod  
21 can refer us to data which will let us know just what you  
22 are talking about.

23 MR. MACLEOD: The comparable product I am  
24 referring to is Tetracycline. The dosage forms are the  
25 same. The capsules of 250 kilograms, the reported packa-  
26 ging costs, verified by the company in the United States  
27 were for capsules and other material 17 cents....labour  
28 and overhead, finishing operations 13 cents; packaging  
29 cost material, labour and overhead 11 cents, which comes  
30 to a total of 41 cents.



1 THE CHAIRMAN: Mr. MacLeod, are you assuming,  
2 or have you evidence to show, that all that Fine Chemicals  
3 did or do with chloramphenicol is packaging operation?

4 MR. MACLEOD: I am not concerned with Fine  
5 Chemicals sir. I am concerned with Parke-Davis. Parke-  
6 Davis starts out with this drug which costs \$90. It is  
7 reasonable to suggest, I assume, or I suggest from the  
8 table in the Kefauver Report which was certified by the  
9 companies themselves that the cost would be of packaging  
10 and preparing would be somewhat similar; not necessarily  
11 the same but somewhat similar to this involved in tetra-  
12 cycline. To process the same dosage form of tetracycline  
13 is of the order of \$16.

14 THE CHAIRMAN: What we are getting confused  
15 about is as to whether the operation that you are talking  
16 about is a packaging operation which you described as the  
17 several costs, whether that is all that is involved in  
18 what you are describing here, or whether there is something  
19 in addition to that. What you have described as the \$16 is  
20 that what is involved here or is there more involved?

21 MR. MACLEOD: I can only tell you sir in  
22 the case of the similar dosage form the figures are on  
23 the record that those are all the costs that are involved.

24 MR. HUME: Where are they on the record?

25 THE CHAIRMAN: That means this, does it,  
26 Mr. MacLeod: that when Fine Chemicals manufactures chloram-  
27 phenicol at \$90 per kilogram all that should remain to be  
28 done is packaging and labelling?

29 MR. MACLEOD: As far as Fine Chemicals go  
30 the information we were supplied with is they sell it in





1 bulk. They might sell a lot of - I don't know how much is  
2 purchased at one time. One kilogram or 10 kilograms. A  
3 company would buy say 5 kilograms of chloramphenicol from  
4 Fine Chemicals and suitable packaging would be done.

5 THE CHAIRMAN: Is there anything else much  
6 to do?

7 MR. MACLEOD: Not by Fine Chemicals.

8 THE CHAIRMAN: To get to the position where  
9 it is packaged, by the time it is packaged, has something  
10 else been done in addition to the packaging? The company  
11 acquires chloramphenicol from either Parke-Davis or from  
12 Fine Chemicals?

13 MR. MACLEOD: Yes.

14 THE CHAIRMAN: Now at that time they bought  
15 it in bulk by the kilogram?

16 MR. MACLEOD: Yes.

17 THE CHAIRMAN: Is all that remains for them  
18 to do the matter of packaging and labelling or do they add  
19 something to the chloramphenicol or any further process  
20 they go through in addition to packaging?

21 MR. MACLEOD: I am not familiar with the  
22 technical details but in the case of the product that is  
23 quite similar, the antibiotic, it is stated on its face,  
24 as in the case of chloramphenicol and in the case of this  
25 other drug for which we have costs--and it appears to be  
26 a comparable one the total cost of preparing the bulk  
27 drug leading to putting it on the dealer's shelf would be  
28 of the order of \$16 for a kilogram.

29 MR. HUME: Mr. Chairman, if Mr. MacLeod can  
30 I make this now as a formal objection, if Mr. MacLeod can



1 undertake as a solicitor that these questions are relating  
2 to the subject of trade or commerce and which conditions  
3 or practices are related to monopolistic situations or  
4 restriction of trade, then I object to his questions  
5 because we are not concerned with whether Parke-Davis is  
6 making a big profit or a small profit in Canada or in the  
7 United States.

8 MR. MACLEOD: I am suggesting that this line  
9 of questioning of Professor Dixon is to obtain his opinion  
10 as to whether there is not a monopolistic situation here  
11 in order that this high selling cost in relation to pro-  
12 duction cost can continue to obtain and has obtained over  
13 a period of 10 years.

2 14 THE CHAIRMAN: I thought that is what your  
15 question is leading to.

16 MR. HANSARD: I wonder Mr. Chairman, seeing  
17 as it is now approximately ten-to-five and it is obvious  
18 that the witness will not be finished, if Mr. Frawley is  
19 going to examine him ---

20 THE CHAIRMAN: I thought we might finish  
21 with this question.

22 MR. HANSARD: I was going to suggest that  
23 perhaps Mr. MacLeod would like to go out and take another  
24 run at it.

25 THE CHAIRMAN: Do you think we would save  
26 time if we do not complete it now?

27 MR. MACLEOD: Let me put it this way: the  
28 source of the computed cost of preparing dosage forms is  
29 based on the table set out on page 24 of the Kefauver  
30 Committee Report.



1/PB/hm

1 THE CHAIRMAN: Are you nearly through?

2 MR. MacLEOD: There are a few other things

3 I would like to deal with. If we are going to have the  
4 pleasure of having Dr. Dixon sometime next week I think  
5 I will leave it.

6 DR. DIXON: There is something I would like  
7 to say. I can't answer the question on the basis of the  
8 information you have given me. I think I should say if  
9 you want to provide more information -- I don't know the  
10 relevant cost of production dosage form on the U.S. market  
11 and the Canadian market. I don't know the administration  
12 cost, manufacturing cost, the distribution cost of the  
13 drug. Until I have this I couldn't answer the question  
14 what relevancy this ninety has to the raw material to the  
15 final selling price.

16 MR. MacLEOD: We could leave it till next  
17 week.

18 MR. HUME: I am in trouble myself about next  
19 week. I have commitments to appear in Toronto on Monday.  
20 I hope I will be able to avoid it. I am working on a  
21 settlement. I will definitely not be able to be here on  
22 Tuesday or Wednesday or Friday of next week. Dr. Dixon  
23 being my witness I want to be here and the only time he  
24 can come next week is Tuesday.

25 DR. DIXON: Or Friday.

26 MR. HUME: As the Chairman indicated there  
27 might be further argument. I am thinking along the lines,  
28 if we are going to come back for argument and I would like  
29 to have time to review the transcript, possibly then we  
30 could clean this up later in Ottawa.



1 THE CHAIRMAN: We will see where we stand  
2 on that situation a little later, near the end of this  
3 hearing. If counsel feel they need time to prepare final  
4 argument we will consider setting another date.

5 MR. HUME: I apologize to the Commission.  
6 I had no idea this would require my attendance like this  
7 next Tuesday. I realize Dr. Dixon must leave. We will  
8 be here tomorrow with Mr. Conder. We will have to try and  
9 work something out.

10 THE CHAIRMAN: Mr. Conder is not the last.

11 MR. HUME: I am responsible. I am appearing  
12 as counsel.

13 MR. FRAWLEY: I might observe we might  
14 examine my situation in the light of what the circumstances  
15 are. As far as I am concerned I take a rather serious  
16 view of Dr. Dixon's evidence. He certainly puts his  
17 blessing on the price structure. The price structure, there  
18 is nothing wrong with that. It doesn't matter there is  
19 drug competition on the price structure. I challenge that.  
20 I would like to ask him some questions about that. My  
21 friend, Mr. Hume, notwithstanding what my friend says - he  
22 is going to object to any questions on price. I have a  
23 document in front of me which the witness prepared. He  
24 talks about prices. Surely at this stage we are not  
25 going to be shut off from cross-examining the witness.

26 DR. DIXON: I beg your pardon, that particular  
27 statement wasn't prepared for this Commission. It is in  
28 an exhibit and not on the record.

29 MR. FRAWLEY: I thank you for your frankness.  
30 I direct my castigation, if you call it that, to my friend,



1 Mr. Hume. It is part of the record in these proceedings.

2 That is all.

3 THE CHAIRMAN: It had been prepared for  
4 another purpose.

5 MR. FRAWLEY: Let us withdraw it.

6 THE CHAIRMAN: Some of it is relevant to  
7 the proceedings here and rather than cut out parts the  
8 whole thing was left with us.

9 DR. DIXON: I commented on what I thought  
10 were the relevant parts.

11 THE CHAIRMAN: We can ignore the parts we  
12 are not to look at.

13 MR. FRAWLEY: It is all open to questions.

14 MR. HANSARD: What about the Kefauver report?

15 THE CHAIRMAN: If it is not relevant to  
16 the proceedings I don't think we will pay much attention  
17 to it. I hope we won't.

18 MR. HUME: I have the problem of trying to  
19 be at two places. Dr. Dixon, I understand you are excusing  
20 him tonight. You have to be back in Kingston. What I am  
21 trying to do is to see whether or not some arrangement  
22 can be made. I will do my best to try and relieve myself  
23 of the Tuesday court responsibility. If that is not  
24 possible I just don't know what to suggest. Perhaps I  
25 could speak to it tomorrow.

26 MR. FRAWLEY: I am all in favour of adjourning  
27 to Ottawa.

28 THE CHAIRMAN: I think we will have to adjourn  
29 now, Dr. Dixon. Mr. Hume you will perhaps know tomorrow?

30 MR. HUME: I will be here.





1 THE CHAIRMAN: You might know tomorrow what  
2 your position is. Dr. Dixon, you are available on Tuesday  
3 and Friday next week. We will have to see what turns up.

4 MR. CONDER: We have our Annual Meeting of  
5 our Association on October 30th and 31st. I would like to  
6 direct that to your attention in case these arrangements  
7 go a little further. It would be most difficult for us  
8 to be here on these two dates. We are having all our  
9 companies there. We have issued our official notice of  
10 the annual meeting.

11 MR. FRAWLEY: All the direct mailing has  
12 been done.

13 THE CHAIRMAN: If the proceedings have to  
14 be adjourned we will have to fix another hearing date. We  
15 won't go ahead when people cannot be here. Perhaps tomorrow  
16 you will be able to let us know better how you are fixed.

17 We will adjourn now until tomorrow.

18  
19 ---Whereupon the hearing adjourned until 10 a.m.,  
20 Friday, October 20th, 1961.

21  
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ANGUS, STONEHOUSE & CO. LTD.  
TORONTO, ONTARIO

INQUIRY UNDER SECTION 42  
OF THE COMBINES INVESTIGATION ACT

Relating to the manufacture, distribution and sale  
of drugs

By Director of Investigation and Research  
Combines Investigation Act

COMMISSION:

C. RHODES SMITH, Q.C.	--	Chairman
A.S. WHITELEY, M.A.		Member of the Commission
PIERRE CARIGNAN, Q.C.		Member of the Commission
F.N. MACLEOD		Combines Officer,
representing the Director of Investigation and Research		

Proceedings of hearings commencing at  
10.00 a.m., Friday, October 20th, 1961,  
et seq in the City of Toronto, in the  
Province of Ontario.





1 THE CHAIRMAN: Shall we resume the hearing,  
2 ladies and gentlemen? I believe counsel has some  
3 suggestions in connection with any possible adjournment,  
4 and we will have the discussion off the record.

5  
6 ---Off the record discussion.

7  
8 THE CHAIRMAN: Gentlemen, who was wishing  
9 to open the questioning this morning? Are you proceeding  
10 then, Mr. Frawley?

11 MR. FRAWLEY: Yes.

12 Mr. Conder, will you look at Appendix B.

13 MR. CONDER: Appendix B?

14 MR. FRAWLEY: Appendix B, yes. Members of  
15 your Association. Abbott Laboratories Limited, Montreal,  
16 do you know whether they are a wholly-owned Canadian company  
17 or wholly or partially owned in Canada or outside of  
18 Canada?

19 MR. CONDER: Abbott Laboratories to the best  
20 of my knowledge, Mr. Frawley, are a Canadian company acting  
21 as a subsidiary of a foreign corporation.

22 MR. FRAWLEY: And the name of the foreign  
23 corporation is Abbott Laboratories in Chicago?

24 MR. CONDER: I am not absolutely certain of  
25 the exact names of the foreign corporations. I would  
26 presume that the name of the company in Chicago would be  
27 "Abbott".

28 MR. FRAWLEY: Would be what?

29 MR. CONDER: Abbott.

30 THE CHAIRMAN: I wonder if the witness is in



1 a position to state authoritatively what the position of  
2 these companies is with respect to foreign ownership, the  
3 degree of control, whether they are wholly or partially  
4 owned subsidiaries, who is the parent. Are you in a position  
5 to give us the facts with assurance that they would be  
6 correct?

7 MR. CONDER: No sir, I could not do so with  
8 assurance.

9 MR. FRAWLEY: I have some questions to ask  
10 and I would like to be permitted to ask them and get them  
11 on the record. I want to ask the witness because he is  
12 the only witness. Nobody is coming from Abbott Laboratories  
13 Limited so far as I know.

14 THE CHAIRMAN: You could ask the witness  
15 whether he knows the answer. I am sure you will get it.

16 MR. FRAWLEY: Bristol Laboratories of  
17 Canada Limited in Montreal is, I put it to you, as the  
18 information appears in the Green Book, -- and then you  
19 can make such comment as you choose or are able to make.  
20 Bristol Laboratories of Canada Limited is a subsidiary,  
21 it would appear, of Bristol-Myers Company of New York.

22 MR. CONDER: I do not know whether Bristol  
23 Laboratories of Canada Limited is a direct subsidiary of  
24 Bristol-Myers Company of New York. If it appears in the  
25 Green Book I would presume, Mr. Frawley, the author of the  
26 Green Book has checked that out and he has access to  
27 certain information I do not have in these things.

28 MR. HANSARD: Isn't the question of these  
29 companies all covered in the Green Book and all covered,  
30 I presume, by information obtained by the director.





1 THE CHAIRMAN: Perhaps Mr. Frawley is seeking  
2 to show some variation from the facts in the Green Book.

3 MR. HANSARD: Oh well, if he is doing that.

4 MR. FRAWLEY: I don't know that the Green  
5 Book indicates whether or not, for instance, Bristol-Myers  
6 Laboratories of Canada Limited is wholly owned or only  
7 partially owned by Bristol-Myers Company of New York. It  
8 is in a list of companies starting on page 264 and it is  
9 information supplementary to this list that I want to  
10 obtain from the witness.

11 MR. HANSARD: He is not the best witness to  
12 give it. How would he know?

13 MR. FRAWLEY: The fact is that I would not  
14 be asking this question if Abbott were here or if we had  
15 any information that Abbott is going to be here, but from  
16 anything I have heard so far, I have not heard that Abbott  
17 Laboratories are coming forward to be questioned; so  
18 therefore I have to do the next best thing. It is on that  
19 basis that I respectfully think I should be allowed to  
20 pursue these questions.

21 THE CHAIRMAN: Let him ask the question, but  
22 I am afraid we will be wasting quite a bit of time because  
23 I very much suspect the witness cannot answer that.

24 MR. FRAWLEY: I want the record to show that  
25 these companies are not here, and that therefore I am  
26 getting second best and perhaps very unsatisfactory answers  
27 from the witness.

28 MR. HUME: I will clear that up in a word.  
29 The companies are not here and Mr. Conder as general manager  
30 of the Canadian Pharmaceutical Manufacturers Association



1 only knows what he has been told, I presume, and that is  
2 the whole basis on which it is submitted, and you may take  
3 it from him that these companies are not themselves here.

4 MR. FRAWLEY: That was not the contention.  
5 I thought that was freely admitted.

6 Do you know whether or not there is any  
7 Canadian shareholdings at all in the Abbott company, the  
8 first one I mentioned, or in the Bristol Laboratories of  
9 Canada Limited?

10 MR. CONDER: I know nothing whatever about  
11 the shareholdings of those two companies.

12 MR. FRAWLEY: Do you know whether or not  
13 the Ciba Company Limited of Dorval Quebec is a subsidiary  
14 of Ciba Limited from Basle, Switzerland?

15 MR. CONDER: Yes, that is correct to the  
16 best of my knowledge.

17 MR. FRAWLEY: Do you know whether or not  
18 there is any Canadian shareholdings in Ciba Limited or  
19 whether the shareholdings are all in Ciba Limited of  
20 Basle, Switzerland?

21 MR. CONDER: I know nothing whatever about  
22 the shareholdings of Ciba Limited.

23 THE CHAIRMAN: Do you know anything about  
24 the shareholdings of any of these companies?

25 MR. CONDER: No sir, I don't.

26 MR. FRAWLEY: The next company -- there are  
27 not very many of them, Mr. Chairman -- the next company  
28 is listed in your list of members as Cyanamid of Canada  
29 Limited, Montreal. Do you know that that is a company  
30 that is a subsidiary of American Cyanamid of New York?



1 MR. HANSARD: They were here.

2 THE CHAIRMAN: That is a question that  
3 might have been asked of Mr. Thompson.

4 MR. FRAWLEY: Yes.

5 MR. CONDER: It is my understanding that  
6 that is the case.

7 MR. FRAWLEY: Do you know whether or not  
8 there is any Canadian shareholdings in Cyanamid of Canada  
9 Limited, or whether the total shareholdings is in American  
10 Cyanamid Company of New York?

11 MR. HUME: The witness has said he knows  
12 nothing about the shareholdings of any of the companies on  
13 the list.

14 MR. FRAWLEY: The Eli Lilly and Company of  
15 Canada Limited, is, according to the Green Book, a sub-  
16 sidiary of Eli Lilly Company of Indianapolis.

17 MR. HUME: I object to the question, Mr.  
18 Chairman.

19 MR. FRAWLEY: On what ground?

20 MR. HUME: Because the witness has already  
21 said he knows nothing about any of the shareholdings on the  
22 list.

23 MR. FRAWLEY: That is all he has to say and  
24 all I am is seeking is to go through the names of about  
25 four more companies, and if that is the only answer I can  
26 get, that is the only answer I will have on the record.

27 THE CHAIRMAN: He has said as far as these  
28 shareholdings are concerned he has no knowledge of any  
29 shareholdings of any companies, and as far as that question  
30 is concerned, he has given you his answer.



1 MR. FRAWLEY: I would like to put my question  
2 with respect to Merck Sharpe and Dohme of Canada Limited,  
3 Pfizer Canada, Schering Corporation Limited, Smith Kline  
4 and French IAC and E. R. Squibb and Sons of Canada Limited  
5 and the Upjohn Company of Canada and John Wyeth and Brother  
6 (Canada) Limited.

7 If you would prefer to have my question put  
8 all in one, it may serve the same purpose. I certainly  
9 don't want to be accused of wasting the time of the  
10 Commission.

11 MR. HUME: It was answered.

12 THE CHAIRMAN: The witness has already said  
13 he knows nothing about who owns the shares, and that is his  
14 position, and I don't think we can get anything more out  
15 of him.

16 MR. FRAWLEY: Well then in order to get the  
17 record clear, with respect to Merck Sharpe and Dohme of  
18 Canada Limited, Parke Davis and Company Limited, Schering  
19 Corporation Limited, Smith, Kline and French IAC, E. R.  
20 Squibb and Sons of Canada Limited, the Upjohn Company of  
21 Canada, John Wyeth and Brother (Canada) Limited, you don't  
22 know whether or not there is any Canadian shareholdings in  
23 those companies or whether, on the contrary, the total  
24 shareholdings are in the American parent company?

25 MR. CONDER: No.

26 MR. FRAWLEY: You don't know?

27 MR. CONDER: I know nothing whatever about  
28 the shareholdings of these corporations.

29 MR. HUME: That is the fourth time he has  
30 said that.



1 MR. FRAWLEY: Now, I would like to ask you  
2 some questions with regard to broad spectrum antibiotics,  
3 ataractics and cortico-steroids. Those are the products  
4 in which I am interested and I would like to ask you whether  
5 or not you are able to give me any answers at all with  
6 respect to what it costs those companies whose names I have  
7 given to you to make the broad spectrum antibiotics, the  
8 ataractics and the cortico-steroids that are shown in the  
9 Green Book as being products of those companies.

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1 MR. CONDER: If the competitors in these  
2 companies certainly don't know the answer to this question,  
3 I can assure you, Mr. Frawley, I certainly do not.

4 MR. FRAWLEY: You are not able, and I put  
5 it on that ground, it is not a matter of unwillingness, you  
6 are not able to give the Commission any information or  
7 answer any questions by me with respect to the cost of  
8 making Achromycin, if it is made in Canada.

9 MR. CONDER: I know nothing whatever about  
10 the cost of making Achromycin in Canada.

11 MR. FRAWLEY: Do you know anything about  
12 making Polycycline in Canada by Bristol?

13 MR. CONDER: Nothing whatever.

14 MR. FRAWLEY: Do you know anything concerning  
15 the cost of making Tetracycline by Pfizer?

16 MR. CONDER: No.

17 MR. FRAWLEY: Do you know anything about  
18 the cost of making Steclin by Wyeth?

19 MR. CONDER: No.

20 MR. FRAWLEY: Do you know anything about  
21 making Panmycin by Upjohn?

22 MR. CONDER: No.

23 MR. FRAWLEY: Do you know anything about --

24 THE CHAIRMAN: Mr. Frawley, is there any  
25 reason why he should know? What makes you think he would  
26 know it? He has said he doesn't know about that company  
27 or any other company. It would appear to me he cannot  
28 answer any of the questions. He is not acting for the  
29 individual companies, and there certainly is no information  
30 to us that they supplied him with the cost break-downs.



1 MR. FRAWLEY: But, Mr. Chairman, I want  
2 the record to show in the absence of these companies that  
3 the Association to which they belong has no information  
4 with respect to these matters upon which I am seeking  
5 information on behalf of my people.

6 THE CHAIRMAN: I understand that, but I  
7 think the witness has given the answer.

8 MR. FRAWLEY: I want it with respect to  
9 product by product, if there is a record being made, that  
10 is why I want to know. I would just wrap it all up in  
11 one question, but I am seeking to make it awfully clear  
12 what the effect is of the absence of these companies coming  
13 forward.

14 THE CHAIRMAN: Well, proceed with the  
15 question then.

16 MR. FRAWLEY: Do you have any information,  
17 Mr. Conder, with respect to the cost, Schering's cost of  
18 making Meticorten?

19 MR. CONDER: No.

20 MR. FRAWLEY: Do you have any information  
21 with respect to Schering's cost of Meticortelone?

22 MR. CONDER: No.

23 MR. FRAWLEY: Do you have any information  
24 with respect to Lederle's cost of Aristocort?

25 MR. CONDER: No.

26 MR. FRAWLEY: Do you have any information  
27 with respect to Squibb's cost of Kenocort?

28 MR. CONDER: No.

29 MR. FRAWLEY: Do you have any information  
30 with regard to Merck's cost of Decadron?



1 MR. CONDER: No.

2 MR. FRAWLEY: Do you have any information  
3 with regard to Schering's cost of Deronil?

4 MR. CONDER: No.

5 MR. FRAWLEY: Do you have any information  
6 with respect to Wallace's cost of Miltown, or whoever the  
7 Canadian manufacturer or distributor of Miltown is?

8 MR. CONDER: No.

9 MR. FRAWLEY: Do you have any information  
10 with regard to Wyeth's cost of Equanil?

11 MR. CONDER: No.

12 MR. FRAWLEY: Do you have any information  
13 with respect to Smith, Kline and French's cost of  
14 Thorazine?

15 MR. CONDER: No.

16 MR. FRAWLEY: Do you have any information  
17 with respect to Smith, Kline and French's cost of Compazine?

18 MR. CONDER: No.

19 MR. FRAWLEY: Do you have any information  
20 with regard to Wyeth's cost of Sparine?

21 MR. CONDER: No.

22 MR. FRAWLEY: Do you have any information  
23 as to the constituent parts, the components of the price  
24 of the spread between the cost to these corporations for  
25 these products and the list price at which they are sent  
26 out to their plants in Canada?

27 MR. CONDER: Would you care to rephrase that  
28 question. I don't understand it.

29 MR. FRAWLEY: Do you have any information  
30 with regard to the components which make up in dollars or



1 cents per product, what components make up the difference  
2 between the cost to these companies for these products and  
3 the list price at which they are put on the shelves in the  
4 retail stores?

5 MR. CONDER: When you qualified your answer  
6 right now you said the price or the cost factors involved  
7 in these products. We do know, for example, when a Canadian  
8 company manufacturing in Canada turns a product out, that  
9 it must pay wages and salaries to employees and other  
10 factors which go into that product.

11 These are all added to the initial price of  
12 the raw materials, and go towards bringing up the cost  
13 of manufacturing, to that cost. Insofar as individual items  
14 concerning these costs or the prices involved, I know  
15 nothing whatever.

16 MR. FRAWLEY: I do not wish that there  
17 should be any lack of understanding between the questioner  
18 and answerer.

19 MR. CONDER: There is none on my part, Mr.  
20 Frawley.

21 MR. FRAWLEY: But I don't want it to arise  
22 by immaturity of my questioning, Mr. Conder. If you assume  
23 with me that the list price of Schering's Meticorten in  
24 retail drug stores in Alberta is \$22.70 per hundred ---

25 MR. CONDER: I cannot assume that.

26 MR. HANSARD: May I ask my friend not to  
27 put assumptions into the witness' mouth or anywhere else.

28 MR. FRAWLEY: Right now I am going to make  
29 a statement. Yesterday or two days ago we had an exhibit  
30 marked T -- I didn't even make a note of it because it was



1 not offered. T-7 I think it was. This is the exhibit that  
2 I was discussing.

3 THE CHAIRMAN: We reserved a number for it.

4 MR. HUME: T-5.

5 THE CHAIRMAN: We reserved a number pending  
6 when it is introduced.

7 MR. HUME: The letter from Dr. Rodman.

8 MR. FRAWLEY: With the attachment. It is  
9 the attachment that is important, but that went into the  
10 T-5.

11 MR. HUME: That number has been reserved  
12 for it.

13 MR. FRAWLEY: It was understood that as the  
14 result of what was put to me with regard to the validity  
15 of University Hospitals' prices -- University Hospital in  
16 Edmonton's prices, that I should supplement, which informa-  
17 tion was not on the statement. Therefore I was to obtain  
18 that information.

19 I have been in communication with Edmonton  
20 for that purpose, and as soon as it is possible to obtain  
21 the information and reproduce it, then I will be fulfilling  
22 my obligation to the Commission to offer that document  
23 that has already been given a number.

24 In that document there will be shown prices  
25 paid by wholesalers, by wholesalers in Edmonton, paid by  
26 druggists in Edmonton and the list price, namely paid by  
27 the patient with the prescription. Now, that will be in  
28 the statement, and on that basis I answer my friend Mr.  
29 Hansard's objection, and I am reading now from the state-  
30 ment. If when the statement is offered, the list price of





1 Meticorten in Edmonton is not \$22.70 but something else,  
2 then the record will be amended accordingly. I have no  
3 reason to doubt the figure of \$22.70 is the list price of  
4 Schering's Meticorten in Edmonton.

5 On that basis I would like to put the question  
6 to the witness, certainly with the understanding there  
7 will be an exhibit filed to establish what that list price  
8 is.

9 THE CHAIRMAN: What is the question?

10 MR. FRAWLEY: The question is, assuming with  
11 me, Mr. Conder, that the list price of Meticorten is  
12 \$22.70 for 100 tablets in Edmonton -- in other words, that  
13 is the list price as it is commonly known -- are you able  
14 to give me any break-down in that \$22.70 into the cost of  
15 making or importing the drug, the cost of formulating it,  
16 the cost of getting it from the Canadian plant to the retail  
17 shelf of the druggist, and whatever other components would  
18 go into it between those two prices?

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1 MR. CONDER: In the first place Mr. Frawley  
2 I think you are expecting much of me to assume a  
3 statement based on something about which I have no know-  
4 ledge whatever, such as prices of this particular product.  
5 Maybe your statement is correct. It may be incorrect.  
6 I have no knowledge whatever of this.

7 THE CHAIRMAN: Answer the question Mr. Conder  
8 on the basis of whatever the price may be.

9 MR. CONDER: Regardless of what the price  
10 of this product may be Mr. Frawley I have no knowledge  
11 whatever as to the individual costs involved in the  
12 various stages for manufacturing which lead from the formu-  
13 lation of the raw materials into the selling price of the  
14 product.

15 MR. FRAWLEY: That is right. Now Mr. Conder  
16 then you are not able to give the Commission - because  
17 you are without such information. You are without any  
18 information as to how much it costs Schering to distribute  
19 and promote Meticorten and get it from the plant into the  
20 retail shelves?

21 MR. CONDER: Not on that product alone, no.

22 MR. FRAWLEY: And you are not able to tell  
23 me what it costs Schering to put this product, Meticorte-  
24 lone, on the retail shelves under the heading of promotion,  
25 direct mail promotion, detailmen, etc. etc.?

26 MR. CONDER: Not other than the figures for  
27 the National Average, or the average of all our companies  
28 which is borne out in our submission.

29 MR. FRAWLEY: With the greatest of respect  
30 I am not in the slightest interested because, with the



1 greatest of respect I think they are entirely meaningless.  
2 Now are you able to give me or give the Commission any  
3 information of the kind I have just been asking with  
4 respect to any of the products to which I have referred  
5 you within the last ten minutes of my questioning?

6 MR. CONDER: None whatever.

7 MR. FRAWLEY: You are here completely  
8 bereft of any information showing the make-up of the  
9 price cost, as to cost - the cost component - when I say  
10 cost, I mean the expense component or the profit component  
11 of the list price of any of the drugs, any of the broad  
12 spectrum antibiotics, ataractics or cortosteroids?

13 MR. CONDER: Not individual products Mr.  
14 Frawley because we do in our representation show an  
15 average for the operations of all companies. It may be  
16 presume that these companies break down their averages  
17 based on the sales of these particular products.

18 MR. FRAWLEY: Are you able to give me,  
19 taking all of the tetracyclines, Lederle's Aristocort,  
20 Upjohn's Panmycin, Squibb's Steclin, Pfizer's Tetracycline,  
21 Bristol's Polycycline, taking all those as being repre-  
22 sentative and perhaps exclusively of the broad spectrum  
23 antibiotics now being sold in Canada, and taking that as  
24 a group are you able to give the Commission the expenses  
25 of getting that into the market as against the profit  
26 that is made in putting it on the market?

27 MR. CONDER: No, not for the individual  
28 products mentioned.

29 MR. FRAWLEY: Not for the individual  
30 products mentioned, but as a group. I am passing from



1 the individual products into the group.

2 MR. CONDER: No, because our figures are  
3 broken down by pharmaceuticals and biologicals.

4 MR. FRAWLEY: Are you able to take the  
5 group of ataractics and give me similar information?

6 MR. CONDER: No.

7 MR. FRAWLEY: Are you able to take the group  
8 of cortosteroids and give me similar information?

9 MR. CONDER: No.

10 THE CHAIRMAN: I think the answer may be  
11 pretty clear Mr. Frawley. He is not in a position to give  
12 us any detailed information.

13 MR. CONDER: That is right sir.

14 THE CHAIRMAN: On any of these individual  
15 drugs.

16 MR. FRAWLEY: The answers are no surprise  
17 to me sir, but I feel I have an obligation to the people  
18 that sent me here to put them on the record.

19 THE CHAIRMAN: In addition to the fact we  
20 may be spending a lot of time on something which we all  
21 know what the answer is. We would like to see some connec-  
22 tion between the actual cost on spread to the issue which  
23 the Commission has to deal with.

24 MR. HUME: I have been sitting in my seat  
25 with great difficulty because I feel Mr. Frawley is about  
26 to launch himself on the same sort of questioning, cross-  
27 examination of Mr. Thompson and I thought I'd just better  
28 see how far he goes. Obviously what he wants to have is  
29 the cost between - the ingredients of cost.

30 Now I have said more than once we do not have



1 the information. Secondly, you have said more than once  
2 you are not interested in it so I think he should not  
3 continue this line of questioning.

4 MR. FRAWLEY: Mr. Chairman perhaps I should  
5 make - try to understand my position. Do I understand  
6 sir that the Commission is not interested in finding out  
7 whether the expense element in the \$22.70, and I ask you  
8 to just accept that as the figure, whether the expense  
9 item as against the expense component - as against the  
10 profit component in the \$22.70 is a matter of no concern  
11 whatever to the Restrictive Trade Practices Commission?

12 THE CHAIRMAN: Standing alone, I don't think  
13 it is part of our duty. It is our duty if it is shown  
14 that that spread, the spread between the cost and the  
15 selling price has adversely affected the public  
16 by some arrangement, some monopolistic control, but if  
17 there is shown to be free competition, and I am using  
18 that in the broad sense, which usually under our Act  
19 includes price competition as well as other types of  
20 competition - if it is shown that this competition is  
21 operating freely, no monopolistic control, no restraint  
22 of trade, our Act does not apply.

23 MR. FRAWLEY: I am anxious to know precisely  
24 the position in which I am put so that I can obtain  
25 instructions.

26 Just assume sir - I want to see how far the  
27 situation goes and how far the Commission stands aside -  
28 supposing - and I am not alleging this is so at all, but  
29 to make the situation quite clear - suppose that an exami-  
30 nation of that price spread, an examination, which I put





1 to you sir, could be made - now nobody has said, Mr.  
2 Thompson did not deny that it could be made - suppose an  
3 examination of that \$22.70 indicated that the cost was  
4 \$2.70, for instance, and that the \$20 was a profit for  
5 the Schering Corporation. Would the Commission say "Well  
6 that looks like a very handsome profit but we are not in  
7 the slightest concerned unless we find that that profit  
8 was arrived at by a collusion between the other manufac-  
9 turers of that cortosteroid"? Am I to understand that  
10 that is the situation?

11 THE CHAIRMAN: It could be another. It  
12 might arise out of a monopolistic control.

13 MR. FRAWLEY: Or some monopolistic control,  
14 but if Schering was fixing that price on its own without  
15 any regard to its associates in the industry this  
16 Commission would not be the slightest concerned with that?

17 THE CHAIRMAN: If Schering has monopolistic  
18 control and as a result of monopolistic control was able  
19 to charge a much higher price than otherwise would be the  
20 case, we would be interested.

21 MR. HUME: I think this brings up a basic  
22 principle. We should clear it up. If my friend Mr. Frawley  
23 had laid any basis indicating that there was such evidence,  
24 then I would be the last one to suggest that these ques-  
25 tions are not relevant, but Mr. Frawley has not laid any  
26 such basis nor has the Green Book. Therefore Mr. Frawley  
27 is fishing and I suggest that unless there is some indica-  
28 tion, some basis indicated that monopolistic control or  
29 collusion was present that these questions are in fact  
30 irrelevant.



1 THE CHAIRMAN: I intimated to Mr. Frawley  
2 that we would be interested in seeing a connection with  
3 the issues the Commission has to deal with.

4 MR. FRAWLEY: Let me just pursue it for a  
5 moment sir. You spoke about - you indicated the Commis-  
6 sion would be interested in whether or not there was any  
7 monopoly. I find in looking at the Ottawa Civic Hospital  
8 Pharmacopoeia, prednisone, which is the generic word after  
9 which the words Meticorten Colisone - now I am not certain  
10 who makes Colisone but perhaps this Commission will bear  
11 with me for a moment until I find out who makes Colisone.

12 MR. HUME: Frosst.

13 MR. FRAWLEY: Frosst makes it. Well now  
14 then, assuming that Frosst and Schering were the only  
15 people marketing the generic product prednisone ---

16 MR. HUME: But they are not.

2 17 MR. FRAWLEY: My friend says they are not.  
18 All I am endeavouring to indicate is that somewhere, some  
19 way, this Commission must be interested in whether or not  
20 there is an excessive profit component in the spread  
21 between the manufacturing cost and the list price. If  
22 this Commission is not I am the first one to be glad to  
23 know so I can report accordingly. If that is so sir I  
24 will be glad to accept it.

25 THE CHAIRMAN: I think I have indicated as  
26 well as I can and on more than one occasion what the  
27 limits are. The jurisdiction of this Commission - the  
28 Act tells us what we are to deal with and we are not  
29 entitled to go beyond that. Section 42, under which we  
30 are operating now, is concerned with monopolistic



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1 situations or situations in which there appears to be  
2 restraint of trade. Now we might come to the conclusion  
3 that there was some restraint of trade under Section 42  
4 but not something which is contrary to Section 32 or 34.  
5 Therefore, there is no offence against the Act but we  
6 might under those circumstances come to the conclusion  
7 that there was something that was detrimental to the  
8 public.

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1 THE CHAIRMAN: It is only on the basis there  
2 is some monopolistic situation or situation involving  
3 restraint of trade; that is all our Act means.

4 MR. FRAWLEY: I want to be quite clear, if  
5 you found - I would think, sir, that your duty would be  
6 to ascertain whether there was monopolistic control or  
7 restraint of trade and in doing that go properly into the  
8 investigation of the expenses as against profits in the  
9 list price.

10 THE CHAIRMAN: Certainly if we saw cases  
11 over a period of time, as far as we could ascertain whether  
12 there was a cost of \$2 and a selling price of \$20 we  
13 might wonder how that had happened. If any evidence was  
14 forthcoming how it had happened we might pursue it. We  
15 have to have some evidence before we can reach a conclusion.

16 MR. FRAWLEY: That is correct.

17 THE CHAIRMAN: Not merely as to the spread  
18 but how the spread occurred.

19 MR. FRAWLEY: That is true. At least knowing  
20 the price spread itself would be interesting, would be of  
21 importance to the Commission. That is all. After you got  
22 the spread that might be enough alone - it would be one of  
23 the compounds of the subject matter of the Commission's  
24 inquiry.

25 THE CHAIRMAN: Unless we have other  
26 evidence or some evidence to show the reason for what  
27 might be the spread...

28 MR. FRAWLEY: First you have to get the  
29 spread. That is my problem. First you have to know the  
30 spread before you can come to any conclusion whether it



1 is a proper one or not.

2 THE CHAIRMAN: This witness is not in a  
3 position to say.

4 MR. FRAWLEY: I want the record to show this  
5 is the only witness being produced by these people except  
6 Mr. Thompson for whom I have the highest regard.

7 THE CHAIRMAN: Mr. Conder is not in a posi-  
8 tion to give us that information.

9 MR. FRAWLEY: Quite right. I suppose I am  
10 asking you to bear with me. I want to be clear - it  
11 applies to that group of so-called high cost drugs, that  
12 we think in Alberta are high cost. That is why I am  
13 limiting myself to these three groups. I want to follow  
14 the matter through these three groups and with these  
15 negative answers I can...

16 THE CHAIRMAN: Hasn't he given you the  
17 answer? There doesn't seem any point in repeating the  
18 same sort of questions and getting the same answer he has  
19 given for these products and these companies. It seems  
20 to me we are wasting time getting into individual products  
21 and individual companies when he says he knows nothing  
22 about it and he is not in a position to know except he  
23 has made some overall averages. He has told us that.

24 MR. HUME: I think the record will show  
25 quite clearly that. I make no apologies for producing  
26 a witness in these conditions. If Mr. Conder was in a  
27 position to give information like that, that would be a  
28 most unusual situation. That would indicate some discussion  
29 in area which I submit is dangerous to discuss.

30 THE CHAIRMAN: In our experience, not





1 entirely unusual, it gives rise to a little suspicion if  
2 he knows the answer. Any other questions?

3 MR. FRAWLEY: It is perfectly futile to  
4 pursue it any further in the light of that.

5 THE CHAIRMAN: Are there any others here  
6 who wish to ask any questions? Mr. MacLeod generally  
7 tends to wind up the questioning. If there is no one,  
8 then will you proceed, Mr. MacLeod.

9 MR. HUME: Mr. Chairman, before Mr. MacLeod  
10 starts, I have neglected to ask you to assign an exhibit  
11 number to a document to which Mr. MacLeod may refer.  
12 That was the submission that was made to the Select  
13 Committee on Drugs on October 24th, 1960. I know you have  
14 it. May I suggest it be given the number Exhibit T-11.  
15 That was a copy only. It is another form, in another  
16 context, but it was the representation made by this  
17 Association to the Select Committee on Drugs on October  
18 24th, 1960, which is referred to in our submission as  
19 Appendix D. It was suggested it might be given No. T-11  
20 so in the event Mr. MacLeod wishes to refer to it he can  
21 refer to it by number.

22 THE CHAIRMAN: That is the document dated  
23 October 24th, 1960?

24 MR. HUME: Yes sir.

25  
26 --- EXHIBIT NO. T-11: Submission to Select Committee on  
27 Drugs on October 24th, 1960.

28  
29 MR. MACLEOD: Mr. Conder, at the very  
30 bottom of page 4 you make reference to - perhaps I should



1 read the sentence: "As a result of competition at the  
2 manufacturers' level reserpine underwent a drastic drop  
3 in price within 18 months of its introduction to the  
4 Canadian market". What do you mean by "competition at  
5 the manufacturers' level"?

6 MR. CONDER: It is my understanding, Mr.  
7 MacLeod, this resulted from competition from other compa-  
8 nies with competing drugs in this area.

9 MR. MACLEOD: Products involving reserpine?

10 MR. CONDER: I presume so.

11 MR. MACLEOD: That is the understanding on  
12 which you based this statement in your brief?

13 MR. CONDER: Yes sir.

14 MR. MACLEOD: A number of companies entered  
15 the field of manufacturing this drug and as a result of  
16 competition the price was drastically reduced?

17 MR. CONDER: I would say that would be part  
18 of it. The result was, as a result, as we say, as a  
19 result of competition at the manufacturers' level, and  
20 this competition was in the area of several other compa-  
21 nies, I believe, who introduced competing products, within  
22 18 months of the introduction of this product to the  
23 Canadian market, and as a result of this the price went  
24 right down.

25 THE CHAIRMAN: Mr. Conder, for the sake of  
26 the record, you state you imagine that would be the case.  
27 Imagination is not always very reliable. Are you reasonably  
28 sure that is the case?

29 MR. CONDER: I am reasonably certain that is  
30 the case.



1 MR. FRAWLEY: I want the record to show two  
2 minutes ago the witness said he knew nothing - he didn't  
3 know the list price in Edmonton of Meticorten.

4 MR. CONDER: Mr. Frawley, you are asking me  
5 about the actual price of the drug. You are asking me  
6 the differential between the material cost and the selling  
7 price of the product. About those things I know little or  
8 nothing whatever. In a case such as this, in the case of  
9 reserpine I have heard of this drop. I don't know what  
10 the reduction in price was itself. I have no knowledge  
11 of the price or make-up of reserpine whatever.

12 MR. HANSARD: I would like to ask my friend,  
13 Mr. Frawley, not to intervene with what the record  
14 obviously would show, anyway. I don't know what the pur-  
15 pose is of his doing it. The record is there and what  
16 the witness has said is there.

17  
18 MR. FRAWLEY: On the opening  
19 day of the hearing my friend, Mr. Hansard,  
20 indicated to the Commission the companies in Montreal  
21 that he represented. I think he named two or three of  
22 them. Mr. Hansard has been here. His clients are not  
23 here. I say with great respect this does not allow Mr.  
24 Hansard to interject any questions at all and talk about  
25 my cross-examination until his clients come here and  
26 present themselves for questioning.

27 THE CHAIRMAN: Counsel can appear on instruc-  
28 tions of clients without the clients being present for the  
29 purpose of argument or holding a watching brief.

30 MR. FRAWLEY: If he is here for argument



1 there is a time for argument and not objecting to my  
2 questions.

3 MR. HUME: It wasn't a question. It was an  
4 interjection.

5 MR. MACLEOD: Coming back to reserpine,  
6 Mr. Conder, did you regard that as a particularly striking  
7 example to be included in the brief?

2 8 MR. CONDER: No sir, I should say this: I  
9 know little about the actual marketing situation of pharma-  
10 ceuticals in Canada, what does happen, but I had heard  
11 about this. I am not in a position to know whether it was  
12 an unusual case or not, but I do know it was a case. That  
13 did happen.

14 MR. MACLEOD: You regarded it as of suffi-  
15 cient importance to include in the brief?

16 MR. CONDER: Yes sir.

17 MR. MACLEOD: Looking at the sentence just  
18 before that you say: "Merck was forced to close its multi-  
19 million dollar penicillin, streptomycin and cortisone  
20 plant outside Montreal as a result of imports from low-  
21 cost countries and some 400 Canadians were out of jobs".  
22 Do you have the 1959 D.B.S. statistics you refer to?

23

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W/hm

1 MR. CONDER: The Medicinal and Pharmaceutical  
2 preparations?

3 MR. MacLEOD: Yes. Do you have it with  
4 you?

5 MR. CONDER: Yes I do.

6 MR. MacLEOD: Could you give me the imports  
7 of penicillin for 1959, penicillin and products of.

8 MR. CONDER: Valued over one million  
9 dollars according to table 11.

10 MR. MacLEOD: What is the precise figure?

11 MR. CONDER: \$1,070,129.00.

12 MR. MacLEOD: And for Streptomycin and  
13 products of?

14 MR. CONDER: \$299,312.00.

15 MR. MacLEOD: And for antibiotics, n.o.p.,  
16 not otherwise provided for.

17 MR. CONDER: \$4,506,202.00.

18 MR. MacLEOD: The figures I am going to  
19 refer to now are taken from the Trade of Canada, the  
20 publication by DBS that shows imports from various countries.  
21 For 1959, for penicillin and products, the total importa-  
22 tions with the last three figures rounded are \$1,070,000.00,  
23 the same figure as reported in the DBS publication. The  
24 breakdown of these figures is as follows: From the United  
25 Kingdom \$87,000.00, from Austria, \$36,000.00, from Denmark,  
26 \$69,000.00, and from the United States \$873,000.00 which  
27 would be approximately 80% of the imports shown. Would  
28 you regard the United States as a low cost country in this  
29 connection? Is that what you had in mind in the brief?

30 MR. CONDER: No, I would not, Mr. MacLeod,





1 but I believe that this statement was borne out in a  
2 presentation made to Ottawa at the time that Merck did  
3 decide to close this plant. This was the premise of their  
4 representation at that time. I doubt whether the figures  
5 for 1959 were the reason for that, because I am sure that  
6 the decision was taken prior to 1959.

7 MR. MacLEOD: The figures for 1958 show a  
8 total importation of penicillin products of \$754,000.00,  
9 \$647,000.00 were in the United States.

10 MR. CONDER: Yes.

11 MR. MacLEOD: The second product you mention  
12 is Streptomycin.

13 MR. CONDER: Streptomycin and Cortisone.

14 MR. MacLEOD: And you gave me the figure  
15 of \$299,312.00?

16 MR. CONDER: Yes.

17 MR. MacLEOD: And rounded here that is  
18 shown as \$299,000.00 and for 1959 of \$299,000.00, \$260,000.00  
19 worth came from the United States. The figures for 1958,  
20 of a total of \$174,000.00 worth of imports, \$139,000.00  
21 came from the United States. So it would appear in respect  
22 to those two products at least that the majority of imports  
23 into Canada were from the United States.

24 MR. CONDER: I imagine it would have a  
25 bearing as well in this case, Mr. MacLeod, that a company  
26 such as Merck, for example, can manufacture at a per unit  
27 cost much cheaper in the United States than it can in  
28 Canada, and that if competition reaches the point from  
29 other countries whereby the company feels that it can sell  
30 at a lower price in Canada, or has reached the stage where



1 it can no longer compete because of imports from other  
2 areas, then it must also commence importing to overcome  
3 the cost of those operations in this country and so bring  
4 its prices into relationship with those other foreign  
5 countries.

6 MR. MacLEOD: Yes, I am not arguing with  
7 you, Mr. Conder. Please understand that. I want to get  
8 quite clear what you had in mind in your brief.

9 MR. CONDER: Yes, I understand that.

10 MR. MacLEOD: The point that strikes me  
11 is in these two instances, at least, your reference to  
12 low cost countries does not apply unless you regard the  
13 United States as a low cost country.

14 MR. HUME: With respect, I think that is  
15 perhaps an unfair question because I thought Mr. Conder's  
16 answer made it clear, at least it does to me, that even  
17 though the amount imported may be very small, if the price  
18 of the unit is such that it is cheaper to manufacture in  
19 the United States, that would result in the closing of a  
20 plant in Canada.

21 MR. MacLEOD: Yes, I just want to get it  
22 clear. I am not arguing about it. He stated he did not  
23 regard the United States as a low cost country, but his  
24 sentence in his brief states that it was the pressure of  
25 imports from low cost countries that caused the plants to  
26 close down, and that is given as the only reason, and I  
27 am simply pointing out to him that in respect of penicillin  
28 and streptomycin, the preponderance of the products imported  
29 into Canada came from the United States. So I suggest your  
30 statement must be qualified to that extent.



1 MR. CONDER: Yes, qualified to this extent,  
2 Mr. MacLeod, that the companies in the United States, by  
3 virtue of their considerable mass production facilities  
4 can introduce a product, bring it into Canada rather, sell  
5 it here on a basis which might conceivably compete more  
6 closely with the product coming in from a lower cost  
7 country, from some country in Europe, for example, whereas  
8 the Canadian company may not be in that position to do so  
9 at the time.

10 MR. MacLEOD: I just want to get it clear,  
11 Mr. Conder. You know as well as I do there has been a lot  
12 of talk about cheap foreign imports, particularly from  
13 Italy, and if you are using low cost there in the sense  
14 referring to the United States, that is one thing. If you  
15 are using low cost as referring to certain European  
16 countries or Japan and places like that, I suggest that  
17 comment must be taken with some reservations, because of  
18 the figures which I have read to you. That is my only  
19 point.

20 THE CHAIRMAN: Mr. Conder, let us get it  
21 clear as to how far this comment of yours is because of  
22 mass production the United States firms can produce more  
23 cheaply than Canadian firms and import and pay the duty  
24 and still be able to sell at a lower price than if it were  
25 made here. We have some evidence put in a couple of days  
26 ago that a great many of these products had a lower Canadian  
27 price.

28 MR. CONDER: Yes, it is in some cases.

29 THE CHAIRMAN: Does that apply to these  
30 products?



1 MR. CONDER: I don't know what the products  
2 are. I do know there is a considerable variance. In this  
3 survey that we included in our brief, for example, we did  
4 not ask for the names of the products themselves. We asked  
5 for the number of products which compared.

6 THE CHAIRMAN: The reason I am asking it is,  
7 so that there may be no confusion on that in my mind. If  
8 Canadian companies make and sell these products for less  
9 than they do in the United States, then your submission  
10 with regard to mass production in the United States, to be  
11 able to make the product there and ship it into Canada and  
12 compete more effectively, than if they made the product  
13 in Canada, would not apply.

14 I was just wondering if those products were  
15 among those in regard to the information we received the  
16 other day.

17 MR. HUME: Mr. Thompson indicated some help  
18 in that regard, and I put this in the event that you may  
19 have overlooked it. He indicated certain products where  
20 mass production technique was available, where one man  
21 pushes a button and the cost there may be cheaper in the  
22 large mass production areas, but in other products where  
23 a great deal of hand labour is involved, then the cost is  
24 perhaps lower, in a country where there is more labour.  
25 If the labour rates are less in Canada than in the United  
26 States, it may separate one production from another.  
27 Certain products, mass produced, may be produced in the  
28 United States, and other products produced cheaper here.

29 THE CHAIRMAN: It does raise a question, of  
30 course, as to the economics of the Canadian plant. If they



1 can import from the United States and pay the duty and  
2 lay it down at a lower cost than they can manufacture  
3 themselves, why are they manufacturing at all in Canada?  
4 Mr. Thompson indicated with regard to some products under  
5 those circumstances they would import.

6 MR. HUME: I think most companies do.

7 THE CHAIRMAN: I was wondering why they  
8 would have the manufacturing here.

9 MR. CONDER: I can give you an example, Mr.  
10 Chairman. Several years ago the bulk goods brought in at  
11 the border, the sales tax was charged on bulk goods brought  
12 in at the border, whereas the company putting these goods  
13 together in Canada paid the sales tax on its selling price.  
14 Obviously it was considerably cheaper for any company to  
15 bring the products in in bulk across the border because  
16 of the saving of sales tax on the differential between the  
17 bulk and the selling price.

18 We had, at that time, a considerable number  
19 of companies which had, I believe, manufacturing plants  
20 here, and which were actually manufacturing products and  
21 turning them out and paying their sales tax on the price,  
22 whereas they might have saved considerable by bringing these  
23 products in in bulk and paying their tax on this bulk at  
24 the border.

25 In talking to some of these companies about  
26 it, some of them said that they felt that by establishing  
27 in Canada that they had an interest in the country and they  
28 had an investment in the country, and as the result they  
29 were going to establish manufacturing plants here.

30 A few companies took the opportunity of





1 getting the saving by bringing products in in bulk at the  
2 border. We, as an association, made a representation to  
3 the Minister of Revenue at that time, recommending that  
4 this differential be eliminated and that the tax apply to  
5 the selling price of the product and not merely to the  
6 price on bulk at entry.

7                   This was made by an association, half the  
8 companies of whom were United States subsidiaries at that  
9 time. Only about two companies were against this particular  
10 move, but the great majority of companies were in favour  
11 of it.

12                   THE CHAIRMAN: I was wondering what changed  
13 the position. You have stated bringing in the product  
14 in bulk, and then completing the manufacture in Canada  
15 apparently gave the Canadian company a somewhat lower price  
16 than if they had imported the finished product from the  
17 United States?

18                   MR. CONDER: It may be the Canadian company  
19 manufacturing here, Mr. Chairman, had to pay a higher price  
20 because the amount of sales tax was greater on the product,  
21 the total amount on the product was greater than on the  
22 product imported in bulk.

23                   THE CHAIRMAN: What changed that situation  
24 so that instead of manufacturing in Canada they imported  
25 from the United States?

26                   MR. CONDER: In what respect sir?

27                   THE CHAIRMAN: Well, I gather from your  
28 evidence that because of some competition --

29                   MR. CONDER: This was one company, yes, in  
30 this case.



1 THE CHAIRMAN: -- from low cost countries,  
2 it had become better to import from the United States.  
3 If it was cheaper to import from the United States, why  
4 wasn't that done in the first place?

5 MR. CONDER: Because they felt they had  
6 an investment in the country and they set up the plant  
7 in the hope of setting up a full-scale manufacturing  
8 operation in this country.

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1 In the case of most international corporations,  
2 and I say in most because it is not the case in all  
3 instances, the international corporation will invariably  
4 in major countries attempt to establish separate manufac-  
5 turing plants in that country. This was attempted by  
6 Merck and Company. They had this plant established here,  
7 I understand, for many years, and then they finally found  
8 it was coming down to the point where it was no longer  
9 economical. Merck was one of the early companies in the  
10 manufacturing of penicillin in Canada.

11 MR. MACLEOD: Now, you made certain state-  
12 ments about the average profit margins narrowing and so  
13 on. The bases for those are the surveys which you made  
14 showing these respective figures of 6.5 ---

15 MR. CONDER: Yes, that is correct.

16 MR. MACLEOD: Now, this may be something I  
17 should have taken up with Professor Dixon, and if you  
18 think it is, just say so: in considering the cost of  
19 Canadian companies, have you taken into account such  
20 factors as those mentioned in respect of tariff which we  
21 were just discussing a moment ago and which are referred  
22 to at page 29, paragraph 57 of the Green Book, and again  
23 on page 223 of the Green Book.

24 MR. HUME: May I have the pages again?

25 MR. MACLEOD: 29 and 223. Now, if we take  
26 the first example there, Mr. Conder, it is obvious any  
27 profit that the company is making on that particular pro-  
28 duct is being made in the United States by its parent;  
29 is that not so?

30 MR. CONDER: Yes.



1 MR. MACLEOD: And if you take the second,  
2 the reverse situation described in the second paragraph,  
3 the American company may not be making a normal profit at  
4 all?

5 MR. CONDER: I have one comment from a  
6 company on this point. The Green Book, I believe, on  
7 page 241, states it may not be a true market price in the  
8 normal manner of the term.

9 MR. MACLEOD: Yes.

10 THE CHAIRMAN: Page 241?

11 MR. MACLEOD: What I referred to here parti-  
12 cularly were the sections dealing with tariff on page 29,  
13 and beginning on page 222 and running to 223. That is  
14 paragraph 391. Are you referring to another paragraph,  
15 Mr. Conder?

16 MR. CONDER: There is just that one point  
17 that was contained at the top of the page there, page 241.

18 THE CHAIRMAN: The end of paragraph 429 or  
19 the beginning of paragraph 430?

20 MR. CONDER: End of paragraph 429.

21 MR. MACLEOD: What was your comment on that,  
22 Mr. Conder?

23 MR. CONDER: It was the only comment that  
24 I have received on this or have, on the strength of this,  
25 and that is the Canadian tariff provides that purchases  
26 between related companies must be on an arm's length  
27 basis at fair market value, and the section of the Customs  
28 Act provides how these fair market values are arrived at  
29 for products which are not sold in the normal course of  
30 trade, and for pharmaceutical chemicals to be further



1 manufactured into pharmaceutical specialty products.

2 It is my understanding from this comment  
3 that the formula is cost plus 50%. I believe the story  
4 on this was explained in the examination of the witness,  
5 Mr. J.S. Deachman, Customs Division, Department of  
6 National Revenue, Ottawa.

7 Aside from that I am not aware of the  
8 tariff structure to any great extent.

9 MR. MACLEOD: My point was not the particular  
10 impact of the tariff structure, but that in fact it  
11 appears to be clear from the tariff structure that the  
12 operations of the Canadian company may not represent the  
13 same cost as what would result from the company say,  
14 operating independently, and if you considered that in  
15 using the figures supplied to you by subsidiaries of  
16 American firms?

17 MR. CONDER: No, we have not considered  
18 that. We have considered our actual operating costs in  
19 Canada at the company level, and have not attempted to  
20 break out in any manner whatever what the charges may be  
21 from the U.S. standpoint other than the charge of research.

22 MR. MACLEOD: Can you give any estimate at  
23 all of the amount of business in this field which would  
24 be done by subsidiaries of American companies as compared  
25 to the overall sales?

26 MR. HUME: I wonder whether Mr. MacLeod  
27 means subsidiaries of American firms specifically, or do  
28 you mean subsidiaries of foreign elements? There are a  
29 lot of these companies that are subsidiaries of, say, the  
30 United Kingdom or Switzerland.





1 MR. MACLEOD: I am glad you pointed that out,  
2 Mr. Hume. Can you give any estimate of the business done  
3 by American subsidiaries or business done by foreign  
4 subsidiaries as a whole?

5 MR. CONDER: No, we have never made a study  
6 of that field.

7 THE CHAIRMAN: Mr. MacLeod, you will be some  
8 time?

9 MR. MACLEOD: Some little time, yes.

10 THE CHAIRMAN: I think we had better have a  
11 break.

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13 --- Short Recess

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MR/hm

1 MR. MacLEOD: Mr. Conder at the very bottom  
2 of page 5 you have reference to "for there are pressures  
3 in favour of importing drugs from abroad which could result  
4 in removing the incentive for domestic manufacturing and  
5 the loss of employment to thousands of Canadians." What  
6 pressures did you have in mind?

7 MR. CONDER: The pressures that are appearing  
8 in newspapers and through other areas; certain political  
9 statements which have been made in the past Mr. MacLeod,  
10 which have suggested that by purchasing generic name  
11 products and bringing them into the country we could lower  
12 the price of drugs in this country.

13 THE CHAIRMAN: Does that really mean that  
14 there are drugs which can be obtained more cheaply from  
15 abroad?

16 MR. CONDER: Yes sir.

17 THE CHAIRMAN: And therefore there is, in a  
18 sense, some pressure to get them?

19 MR. CONDER: Primarily raised -- the pressure  
20 is being brought by companies which are in that business  
21 and through other sources.

22 THE CHAIRMAN: Those that are in that  
23 business are not putting on the pressure. They are just  
24 importing.

25 MR. MacLEOD: Do you regard a company that  
26 imports the basic drug and prepares the dosage form in  
27 Canada as an importer?

28 MR. CONDER: No. It depends on what you  
29 mean by the "basic drug". We mentioned in our introduction,  
30 or in our early stages in here, Mr. MacLeod, that if the



1 product imported is one of several ingredients which may  
2 go into the product that this is then the product which  
3 is placed into dosage form in this country, that dosage  
4 form does constitute manufacturing from our standpoint.

5 MR. MacLEOD: Now what about a product that  
6 contains a single ingredient?

7 MR. CONDER: If the product contains a  
8 single ingredient, I would imagine that you must also have  
9 other non-active ingredients which must go in that. When  
10 this is compounded into dosage form, that would also  
11 constitute manufacturing.

12 MR. MacLEOD: That would also constitute  
13 manufacturing?

14 MR. CONDER: Yes.

15 MR. MacLEOD: So that it is true then that  
16 you would have no objection to people buying the basic  
17 drug from foreign sources provided they carried out the  
18 manufacturing, as you have defined, in Canada?

19 MR. CONDER: Our principle in this case,  
20 Mr. MacLeod, is specifically based on the understanding of  
21 the need for the proper quality control facilities at the  
22 manufacturer's level.

23 Now a company bringing in a raw material,  
24 or an active ingredient, for example, from abroad would  
25 first normally -- and this applies to our companies --  
26 would first normally check this material, have it attested  
27 to, to ensure that it is precisely as stated on the  
28 container and when this is done they would then put it into  
29 their production operation. During the production stage  
30 it might conceivably go through any number of operations.



1 This product would be consistently checked at different  
2 stages of operation. This is the quality control procedure  
3 which we say is built right into the product. When the  
4 product is finished and it comes off the line that product  
5 is again checked to ensure that it is the product and that  
6 no problem has existed in between.

7 We know that, for example, many companies  
8 will have checkers checking on the checkers in these cases.  
9 In other words, it is a double quality control point. If  
10 at a third or fourth stage in the operation you add an  
11 ingredient to it, you have to be certain that that ingredient  
12 that you added is as stated as well as the original one,  
13 and even a non-active ingredient has to be checked to  
14 determine that it is correct.

15 MR. MacLEOD: Provided adequate quality  
16 control is carried out in Canada, you do not object to  
17 the importation of basic drugs?

18 MR. CONDER: No sir.

19 MR. MacLEOD: And your statement in the  
20 brief has no relation to that situation?

21 MR. CONDER: None whatever.

22 MR. WHITELEY: Do you consider these  
23 pressures that you refer to are increasing?

24 MR. CONDER: I would say right now sir that  
25 the pressures, if anything, are diminishing to an extent  
26 because there appears to be a greater understanding in  
27 Canada on what goes into pharmaceutical products; greater  
28 understanding of the need for the quality control, the  
29 testing, and proving of products in Canada. The pressure  
30 is appearing to be diminishing, to a certain extent.



1 We have not heard as much recently, for  
2 instance, about this as we did, say, two years ago.

3 MR. WHITELEY: Do you think this pressure  
4 has any direct economic relationship?

5 MR. CONDER: I think from the long-term  
6 standpoint if the pressures that are being brought to  
7 bear, and if the pressures achieved the result that they  
8 desired, then this could have an economic bearing on our  
9 companies because if drugs were imported -- the more drugs  
10 naturally that are imported, the less opportunity there  
11 is for the manufacturing in Canada.

12 THE CHAIRMAN: You mean, Mr. Conder, when  
13 you say that the pressure are, if anything, diminishing  
14 that the import of drugs from abroad has become relatively  
15 less?

16 MR. CONDER: No sir. I would not say that.  
17 My point was based on this: That the pressures in favour  
18 of importing drugs from abroad about two years ago were  
19 very strong. Many newspapers wrote articles to show the  
20 savings that could be introduced by bringing drugs into  
21 this country from abroad.

22 Those have gradually diminished. I would  
23 not say that that has any bearing directly on the actual  
24 importation of the drug.

25 THE CHAIRMAN: You are not saying there is  
26 any relationship between those two?

27 MR. CONDER: No sir.

28 MR. MacLEOD: You think there is nothing  
29 wrong with the practice provided adequate quality control  
30 was carried out, once the product is in Canada?





1 MR. CONDER: That is correct. There is also  
2 another point to this, Mr. McLeod. We in this industry would  
3 very much like to see a domestic chemical supply industry  
4 formed and established in this country.

5 AS we mentioned in our brief at the present  
6 time it is not feasible for the chemical manufacturers to  
7 establish raw material plants here because they are very  
8 costly and they require a comparatively large market to  
9 make them economical. We would very much hope that in  
10 time to come that this will come about so that we in Canada  
11 will have a fully self-contained unit in pharmaceutical  
12 manufacturing in this country.

13 THE CHAIRMAN: Do you mean that none of the  
14 basic drugs are made or they are relatively unimportant?

15 MR. CONDER: No, I would not say none of  
16 them. Some are, but the majority are imported.

17 THE CHAIRMAN: I was thinking of a company  
18 like Fine Chemicals makes them here.

19 MR. CONDER: Oh, definitely, yes.

20 MR. MacLEOD: Would you say in fact that  
21 the tendency is towards more importation? For instance,  
22 we have the instance of penicillin, streptomycin not  
23 being manufactured now in Canada.

24 MR. CONDER: Yes. This is a matter Mr.  
25 MacLeod of competition and if the companies found that  
26 they cannot compete by the production and manufacture of  
27 these substances in Canada and they can make a considerable  
28 saving by importation direct in dosage form from a parent  
29 company then they are bound to do that.

30 penicillin is the example of that. It has



1 been often stated in this industry that the container  
2 almost costs more than the actual product itself.

3 MR. MacLEOD: Somewhere in your brief you  
4 mentioned the statement that the industry is moving towards  
5 the manufacture of raw materials in Canada.

6 MR. CONDER: It will come about. We have  
7 been fully expecting this. Every now and then I will  
8 receive letters in the office from chemical manufacturers  
9 asking whether we know of any products being made in this  
10 country and they will list these products. We receive this  
11 information from time to time from our companies in the  
12 form of a request of where they would be able to obtain  
13 raw materials in this country.

14 Eventually this will come about. We feel  
15 that the problem at the present time -- I should not say  
16 "we feel" but the chemical industry feels that the problem  
17 at the present time is one of smallness in size of the  
18 Canadian market.

19 The Canadian market is too small for one  
20 to establish this costly manufacturing plant and equipment  
21 for the production of these raw materials. As I say, in  
22 many cases -- there are some naturally being made here in  
23 Canada now but it is a small per cent of the total. When  
24 the market eventually grows and as the size of our popula-  
25 tion increases in this country, which is inevitable, this  
26 means that the market for pharmaceuticals in Canada will  
27 increase likewise and as this market grows, then the  
28 chemical industry will find the position narrowing to the  
29 point where it will eventually become economic to establish  
30 plants of this type in Canada.



1 MR. MacLEOD: In your opinion would you say  
2 the situation is aggravated by the market being fragmented  
3 in this sense: Certain of the subsidiaries tend to rely  
4 on their parent company for supplies? Even having the  
5 manufacture in Canada you can't be assured of getting the  
6 whole Canadian business.

7 MR. CONDER: I would not say that, Mr.  
8 McLeod, because I have heard some of our Canadian Management  
9 saying from time to time that if this product that they  
10 are interested in, or raw materials could be manufactured  
11 in Canada and they could get it here at a price less than the  
12 parent company then they would most certainly do so.

13 MR. MacLEOD: Of course, we have the thing  
14 chasing itself around a circle. Canadian price has got  
15 to get low to get them to buy; Canadian price cannot get  
16 low until they do buy.

17 MR. CONDER: Until the market reaches the  
18 stage where it could support an industry and so bring the  
19 price into range.

20 MR. MacLEOD: Now there is one small point  
21 on page 6. You speak of sales being down for 1961. Wouldn't  
22 that be a result of demands arising out of the prevalence  
23 of sickness and so on, rather than any other factor?

24 MR. CONDER: It could very well be. 1960  
25 was an extremely healthy year for Canadians. The sales  
26 of pharmaceuticals were down considerably as the result  
27 of that.

28 MR. MacLEOD: And that occurred to me,  
29 because in reading this article in Barron's which I referred  
30 to yesterday, May 29, 1961, speaking of Parke Davis it



1 said:

2 "The year to year comparisons were made even  
3 more unfavourable by the fact that results  
4 in January, March of 1960 reflected the  
5 heavy demand for an antibiotic, created by  
6 an epidemic of influenza".

7 So that conditions in the health field do obviously have  
8 a bearing on sales?

9 MR. CONDER: Yes, they would in Canada as  
10 well as in the United States.

11 MR. MacLEOD: Now on page 7 there is a  
12 breakdown of companies and I am not quite clear on it. It  
13 occurs in the third paragraph. You say there are 188  
14 firms and of these 70 are multi-line ethical pharmaceutical  
15 manufacturers. 75 are multi-line proprietary manufacturers.  
16 The balance are agents, wholesalers, retailers who also  
17 manufacture some medicals, some medicinals plus packaging  
18 concerns and other suppliers. So that leaves, according  
19 to my figures, a total of 33 firms which are not multi-  
20 line ethical pharmaceutical manufacturers or multi-line  
21 proprietary manufacturers. Is that your estimate?

22 MR. CONDER: That is an estimate, Mr. MacLeod.

23 MR. MacLEOD: Where in that would you class  
24 such firms as Minard's Liniment which is now of course  
25 part of Beecham's products? Perhaps it was in 1959, I  
26 don't know.

27 MR. HUME: Isn't it 43? You take away 145  
28 from 188 and it is 43, not 33.

29 MR. MacLEOD: You are correct. Where would  
30 you class such firms as Minard's Liniment, Doctor Chase's  
products?



B/dpw

1 MR. CONDER: They would come under proprie-  
2 tary manufacturers, as multi-line proprietary manufacturers  
3 because it is my understanding that they do manufacture  
4 more than one product. They have quite a number.

5 MR. MACLEOD: That was my point, did you  
6 use multi-line in a rather limited sense?

7 MR. CONDER: Yes, the company that makes  
8 for example - there are a number of concerns which may  
9 have an ointment mill out in the back of their establish-  
10 ment in which they actually manufacture an ointment.  
11 They may manufacture one or two ointments. It may be  
12 something established, a substantial side of their  
13 business over the years and has been very attractive  
14 locally from a business sense and they maintained it and  
15 kept it going. This wouldn't be a multi-line company as  
16 such. A multi-line company might be a company that is  
17 manufacturing several different products. By multi-line  
18 I don't use it in a sense of a company manufacturing 150  
19 products, very, very huge company that kind of thing.

20 MR. MACLEOD: Do you recall the furore in  
21 the press about certain small companies in Quebec and  
22 the College of Physicians warned members not to be associa-  
23 ted with such companies?

24 MR. CONDER: I do recall that, yes.

25 MR. MACLEOD: Can you give any estimate of  
26 the number of such companies which were in that field?

27 MR. CONDER: I don't recall that, Mr.  
28 MacLeod.

29 MR. MACLEOD: Do you have any idea if any  
30 of these companies would be included in the 188?





1 MR. CONDER: I imagine they would be.

2 MR. MACLEOD: Could you give any estimate  
3 of the number?

4 MR. CONDER: I am sorry I couldn't do that,  
5 no.

6 THE CHAIRMAN: Would these companies all  
7 be manufacturing proprietaries or would they be manufac-  
8 turing ethical drugs?

9 MR. CONDER: I imagine they could be both,  
10 sir. They were primarily smaller companies which were  
11 manufacturing in the Province of Quebec.

12 MR. HUME: It is the D.B.S. report figure,  
13 188, of 1959. The D.B.S. publication would disclose it,  
14 Mr. MacLeod.

15 MR. MACLEOD: I thought perhaps Mr. Conder  
16 might be able to name them. Mr. Conder has apparently  
17 made some study of the 188, of the types of products sold.

18 MR. HUME: Your question is about certain  
19 companies in Quebec. You haven't named them. If you  
20 name them he may be able to tell you.

21 MR. MACLEOD: I don't know their names,  
22 unfortunately. It is just a group. I don't know if they  
23 are named in the D.B.S. statistics, although I think Mr.  
24 Conder has expressed the opinion probably some of them are.

25 MR. CONDER: Yes, I believe so. This study  
26 of the 188 firms, I might add was a very superficial one,  
27 merely to get an approximation of the breakdown of  
28 companies for the convenience of the Commission.

29 MR. MACLEOD: At the bottom of page 10...

30 THE CHAIRMAN: Before you proceed to another



1 page, Mr. MacLeod, in the middle of page 7 there is a  
2 statement which the Commission is a little interested in.  
3 "Furthermore, this list does not include two major compa-  
4 nies which manufacture ethical pharmaceuticals in Canada,  
5 and which are members of our Association".

6 Have you any objection to telling us who  
7 they are?

8 MR. CONDER: No sir, I will be glad to.  
9 One is Mead Johnson Company of Canada Limited which might  
10 be termed a large company from your terms of reference.  
11 The reason they are not included is because they have  
12 certain other products which are considered food items by  
13 the Dominion Bureau of Statistics and as a result this  
14 company's products are listed in the food products.

15 The Upjohn Company of Canada is another  
16 company not included in here, although I do understand  
17 they have been invited by D.B.S. to participate in the  
18 1960 report which is now under study.

19 THE CHAIRMAN: Those are the two companies  
20 you have reference to?

21 MR. CONDER: Yes sir.

22 MR. MACLEOD: Do you know if that invitation  
23 resulted from their carrying out increased manufacturing  
24 activities in Canada?

25 MR. CONDER: I am afraid I couldn't be  
26 absolutely certain. I do know that Upjohn, several years  
27 ago had not been manufacturing to any extent in Canada.  
28 They have increased their manufacturing considerably since  
29 then. They were manufacturing at the time when the ques-  
30 tionnaire for this 1959 D.B.S. report was sent out to the



1 companies. I do know that. I imagine it would be prima-  
2 rily an oversight on the Dominion Bureau of Statistics'  
3 part. I don't say that critically because it must be  
4 quite a job for them to keep abreast of the large number  
5 of companies in the industry.

6 MR. MACLEOD: I phrased my question impro-  
7 perly. I shouldn't have asked why D.B.S. did it. I was  
8 trying to find out whether they did increase their manu-  
9 facturing activity in Canada. You have indicated they  
10 did?

11 MR. CONDER: Yes, they have.

12 MR. MACLEOD: I direct your attention to a  
13 paragraph on page 10, the second paragraph from the bottom.  
14 "No mere handful of companies controls the pharmaceutical  
15 and medicinal manufacturing business in Canada". I assume  
16 we could apply the figures given there to the figures of  
17 dollar sales on page 7 at the bottom of the page?

18 MR. CONDER: Yes, they are taken from that.

19 MR. MACLEOD: So if the percentages on page  
20 10 apply to the dollar figures on page 7 we could get  
21 some idea of the dollar volume of sales of various types  
22 of firms, various sizes of firms?

23 MR. CONDER: That is correct.

24 MR. MACLEOD: On page 11 you again refer to  
25 the combined sales of antibiotics and ataractics being  
26 down. You suggest that more product diversification is  
27 needed to correct this result. If your other statement  
28 about sickness being a contributing factor is correct,  
29 would diversification of products have very much effect?

30 MR. CONDER: Diversification of products



1 would be very important, Mr. MacLeod, because a company  
2 must have several products to which it can switch its activi-  
3 ties. It never knows from day to day whether a competitor  
4 is going to come out with a competing product, a direct  
5 competing product or an indirect competing product in the  
6 same therapeutic class. It can never tell where its  
7 competition may come from because of the developmental  
8 work which is continually going on in this area.

9 MR. MACLEOD: I wasn't directing your  
10 attention to this point. I was suggesting if state of  
11 health in the country plays a significant part in the  
12 demand for drugs the mere multiplication of products  
13 shouldn't increase the market significantly.

14 MR. CONDER: There are two ways of looking  
15 at this. First of all you have a market of pharmaceuticals  
16 in Canada which naturally must fluctuate according to the  
17 health needs of the people at the time. Companies in  
18 manufacturing towards health needs must naturally take  
19 this into consideration in their production, but equally  
20 and even more important they must take into consideration  
2 21 what the competition is doing, so there is a definite  
22 relationship in this area.

23 MR. MACLEOD: Do you think an increase in  
24 the number of antibiotics on the market would increase  
25 the sale of antibiotics?

26 MR. CONDER: No sir, I didn't mean it that  
27 way.

28 MR. MACLEOD: That is what I was getting at.

29 MR. CONDER: No, I doubt that very much.  
30 What would happen, it would most certainly increase the



1 competition in those lines of antibiotics, and also if  
2 you have a case of 12 companies manufacturing a product  
3 which might be - manufacturing products which might be  
4 used in the same therapeutic cause, you have 11 more  
5 chances to find an even better product because all 12  
6 companies will all be working on that particular formula  
7 trying to find a means of improving it, to try and find  
8 a better product. In other words, to build a better  
9 mousetrap.

10 MR. MACLEOD: I quite agree with that aspect.  
11 I am suggesting more antibiotics wouldn't necessarily  
12 increase the sale of antibiotics?

13 MR. CONDER: Oh, no.

14 MR. MACLEOD: I know the observations you  
15 have made are quite true. On page 12 you give certain  
16 figures as to the number of companies engaged in the  
17 manufacture of antibiotics and ataractics. Do you know  
18 if the 35 companies replying to your survey included the  
19 principal manufacturers of antibiotics and ataractics?

20 MR. CONDER: I believe you will find that  
21 list in the reference number at the back which is the  
22 C.P.M.A. Survey No. 5 which has been filed with the  
23 Commission as an exhibit. You will find the names of  
24 the companies there, Mr. MacLeod. I believe you will  
25 find it is 35 companies which are major companies in this  
26 industry.

27 MR. MACLEOD: I know it could be checked  
28 on the survey. I was wondering if to your knowledge there  
29 are any major manufacturers of either antibiotics or  
30 ataractics which are not included in the figures in your





1 brief?

2 MR. CONDER: There may be one or two.

3 MR. HUME: You said it had been filed as an  
4 exhibit. To prevent confusion it is my understanding it  
5 has been filed. It has been sent to the Commission as a  
6 separate document, has it not? It hasn't been given a  
7 number, this survey. Mr. Conder, when you sent the  
8 survey it wasn't an exhibit?

9 MR. CONDER: This was something I filed  
10 with the Chairman yesterday.

11 MR. HUME: I beg your pardon.

12 MR. CONDER: Yesterday or the day before.

13 MR. HUME: I see. I beg your pardon.

14 Perhaps I could indicate it is Exhibit No. T-6.

15 MR. WHITELEY: It says these are major  
16 companies?

17 MR. CONDER: Yes, they are.

18 MR. WHITELEY: Not all of the major compa-  
19 nies?

20 MR. CONDER: No sir. There was no attempt,  
21 I might add, Mr. MacLeod, there was no attempt at selec-  
22 tion on this. It was part of the survey which went out  
23 to all our member companies. We received returns in this  
24 case from 35.

25 MR. MACLEOD: I appreciate that. I was  
26 just concerned to the point whether there might be large  
27 companies engaged in either antibiotics or ataractics  
28 which weren't covered by your survey. Apparently that  
29 can be checked, which is one point of concern.

30 Now, you have a fairly large section on



1 prices. When you are calculating United States prices  
2 did you take into account the fact that fair trade prices  
3 in the United States are normally 10% below the list price?

4 MR. CONDER: No sir, I didn't.

5 MR. MACLEOD: I realize this would have no  
6 bearing on the return to the manufacturer whatsoever, but  
7 if, in fact, the retailer in the United States chooses  
8 to sell at the fair trade price of 10% below, that would,  
9 of course, have a significant bearing on the relative  
10 retail price in Canada and the United States?

11 MR. CONDER: It would definitely if that were  
12 the case at the retail level in the United States. We used,  
13 as you will recall, three examples. Two examples were  
14 selling prices to retailers whereas the other one was  
15 69 items and naturally was an overall comparison of  
16 prices at suggested list prices, taken from the Green Book,  
17 I might add.

18 MR. MACLEOD: These, I think your brief  
19 specifically states, are comparisons of similar products  
20 made by similar companies in both countries?

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/JW/nm

MR. CONDER:

1  
2 These are the products which are listed in the  
3 Green Book and in some cases as you will recall there were  
4 a couple of examples where you could not get a direct  
5 relationship, in other words where you would have a  
6 suggested list price for 100 in the United States and for  
7 20 in Canada. So I did not consider those. I just took  
8 the one in which there was a direct relationship on the  
9 same quantity.

10 MR. MacLEOD: But in your consideration of  
11 the comparative prices in Canada and the United States,  
12 did you take into account the availability of substitute  
13 products in each country?

14 MR. CONDER: No, these were figures which  
15 were taken directly out of the Green Book. The substitute  
16 products were not considered whatever, nor did we in any  
17 way check the figures which appeared in the Green Book.  
18 We took them at their face value and used them on that  
19 basis.

20 There would be, of course, in some cases  
21 a considerable saving in certain areas according to different  
22 products by different competitors, and that is right within  
23 the area of brand name competitors. There was one point,  
24 Mr. MacLeod, I wonder if it would be possible in checking  
25 over subsequently some of this material which was taken from  
26 the Kefauver Sub-Committee exhibits -- there were further  
27 tables presented as sub-committee exhibits before the  
28 Kefauver investigation which showed that prices of at  
29 least three products in relation to Canadian prices were  
30 certainly not amongst the higher prices in the world. I



1 know this is not in the Green Book and with your permission  
2 I would like to comment on this and possibly read into  
3 the record a few examples.

4 I might add that the accuracy of the  
5 Kefauver tables has been questioned by a number of manu-  
6 facturers in a number of cases, but as we had attempted  
7 to show in this brief, the prices are not out of line with  
8 those in the United States.

9 MR. FRAWLEY: Mr. Chairman, I would like  
10 the record to show, if you please, that the witness  
11 refused to discuss prices in any way with me this morning,  
12 and I want to register my objection to having them put  
13 in the record now.

14 THE CHAIRMAN: I think what he objected to  
15 was giving detailed information which was not in his  
16 possession with regard to the prices of specific products  
17 by certain companies.

18 MR. FRAWLEY: He said he was not aware of  
19 the list prices of Meticorten in Edmonton, for example. I  
20 don't know anything that could be of more general knowledge  
21 than that, and I simply want to make my position clear  
22 that the witness now, to suit his own purpose, is going  
23 into the question of prices and costs and he refused to  
24 go into the question of prices and costs with me this  
25 morning, and if he does it now I want my objection registered.

26 MR. HUME: May I interrupt, now, Mr. Chairman,  
27 and make my objection? Mr. Frawley has misstated the  
28 situation completely. This morning Mr. Conder said he did  
29 not have information with respect to prices of individual  
30 companies of a long list of names which Mr. Frawley read.



1 What he is saying now is that he has a document before him  
2 indicating that certain price lists he has -- he is  
3 reading something -- it is not from his own knowledge --  
4 that certain prices presented to the Kefauver Committee  
5 are questioned or altered and that is a completely different  
6 thing.

7 Mr. Frawley's objection, I submit, is not  
8 in any way relevant, nor should it cast any reflection on  
9 the witness.

10 MR. FRAWLEY: If this is information that  
11 the witness has received from some of the companies which  
12 I discussed and which he said he knew nothing about ---

13 THE CHAIRMAN: I think it was companies in  
14 the United States that objected to the Kefauver figure,  
15 wasn't it?

16 MR. CONDER: Yes sir.

17 MR. FRAWLEY: The witness is going to give  
18 some information about costs in the United States.

19 MR. HUME: Wait until you hear it.

20 MR. CONDER: I think you will understand  
21 when I read the information. If we take the Kefauver table  
22 from the Committee's exhibits, we find that many of them --

23 MR. FRAWLEY: Just a moment, Mr. Conder,  
24 what page in the Kefauver report are you referring to?

25 MR. HUME: Mr. Conder, you present it and  
26 don't pay any attention to these interruptions.

27 MR. FRAWLEY: It is all very well to say to  
28 not pay attention to my interruptions, I simply asked  
29 politely if the witness would refer me to the page upon  
30 which he was going to comment.





1 MR. HUME: It is an interruption and he  
2 can't comment on it.

3 THE CHAIRMAN: It might assist in following  
4 if you have the information.

5 MR. CONDER: No, I am sorry. These are  
6 taken out of the publication and there were no page numbers of  
7 exhibits in the publication.

8 MR. WHITELEY: This must relate to tables  
9 that are reproduced in the Green Book.

10 MR. CONDER: Not directly, I don't believe.

11 MR. WHITELEY: The entire Kefauver record  
12 is not before this Commission.

13 MR. CONDER: The point is that prices in  
14 Canada are among the highest in the world, and that point  
15 is before the Commission, and this was an attempt to show  
16 that in addition to the information which we have given  
17 in our brief of a few examples, we also have a few more  
18 examples which definitely show that with the sales tax  
19 included, prices of certain other products are not  
20 necessarily among the highest in the world.

21 MR. FRAWLEY: Is he going to start talking  
22 now about prices of individual products, the thing that  
23 he would not discuss with me? I hope not, on the ground  
24 of plain fairness --

25 THE CHAIRMAN: There is a difference, Mr.  
26 Frawley, between the witness discussing prices which he  
27 finds in a document,--It is not necessary for him to state  
28 that that is the correct price, but this is a document  
29 which he says was filed with the Kefauver Committee.

30 MR. CONDER: Yes sir.



1 THE CHAIRMAN: And out of which the Kefauver  
2 Committee obtained some figures. He refers to those and  
3 he said some companies object to them. He is not stating  
4 what he knows about the price, it is really a different  
5 thing.

6 MR. FRAWLEY: It is very difficult to know.  
7 I simply want to preserve my objection if he is to refer  
8 to a document prepared for him by his member companies,  
9 and he is using that memorandum ---

10 THE CHAIRMAN: We'd better get that from  
11 the witness and we will know where we stand. If  
12 you are referring to specific data set out in the Kefauver  
13 report, it would be helpful for us to have the reference  
14 so that we can identify it.

15 MR. CONDER: I can give you the reference  
16 from this publication. I don't have it from the Kefauver  
17 report because I don't have a copy of the Kefauver trans-  
18 cript in my possession.

19 THE CHAIRMAN: What is the document you are  
20 referring to then?

21 MR. CONDER: This was taken from the  
22 publication entitled "The Green Sheet". It is "Weekly  
23 Pharmacy Report" prepared by Pharmacy Reports Incorporated  
24 in Washington, D.C., which is a publication which shows  
25 various information on the Kefauver hearings and other  
26 events which occurred during the course of a year.

27 THE CHAIRMAN: Is this an official report  
28 of any kind?

29 MR. CONDER: It is an independent report.  
30 It is sold to companies.



1 MR. WHITELEY: Does this contain only  
2 American prices?

3 MR. CONDER: No sir. This contains three  
4 charts. Each show the United States, Canada, Australia,  
5 Mexico, Italy, Austria, Holland and India.

6 MR. WHITELEY: What is the source of this  
7 information?

8 MR. CONDER: The source of this information  
9 is from the Kefauver exhibits.

10 MR. WHITELEY: Does it give the exhibits?

11 MR. CONDER: They give the exhibits but  
12 there are no exhibit numbers contained on this. They list  
13 this as "Kefauver Sub-Committee exhibit".

14 They give the calculations and the sources  
15 of the information contained in here, the same as in the  
16 other Kefauver exhibits. For example, they will show the  
17 sources of data as the United States, the American Drug  
18 Blue Book 1959 to 1960, foreign prices quoted from the  
19 American Department of State for American industry abroad  
20 for the study of the Sub-Committee in the Spring of 1959.

21 MR. FRAWLEY: This gentleman is going to  
22 comment on that and show wherein the material put before  
23 this Kefauver Committee was wrong or exaggerated.

24 MR. HUME: No he is not.

25 THE CHAIRMAN: What puzzles me at the moment  
26 is what weight we can give to that particular document which  
27 is prepared by a group that we know nothing about in this  
28 country, unless you tell us something about it. Just taking  
29 the figures out of the Kefauver documents and apparently  
30 arranging them in some fashion for some purpose they have,



1 we would like to know to what extent we can rely on them  
2 as being completely accurate.

3 MR. HUME: I would suggest, Mr. Chairman,  
4 that Mr. Conder ---

5 THE CHAIRMAN: -- completely accurate pre-  
6 sentation of what is in the Kefauver document.

7 MR. HUME: Perhaps we can solve this whole  
8 thing. Your purpose in mentioning this to Mr. MacLeod  
9 was, as I understand it, that these were some additional  
10 examples of prices that were taken out of the Kefauver  
11 report by someone else?

12 MR. CONDER: Yes sir.

13 MR. HUME: And they are in addition to what  
14 you have in your brief?

15 MR. CONDER: That is right.

16 MR. HUME: Do they show us anything in  
17 addition to what is in the brief?

18 MR. CONDER: No.

19 MR. FRAWLEY: Mr. Whiteley observed that the  
20 committee proceedings were part of the record and if that  
21 goes in, I will offer my copy of the report dated June  
22 27, 1960 and have it marked as an exhibit before this  
23 Commission.

24 MR. HUME: The report is before the Committee,  
25 but not the record.

26 MR. FRAWLEY: I have all the records in my  
27 office at Ottawa and I will gladly offer them as an exhibit  
28 to the commission.

29 MR. HUME: I will be quite prepared to with-  
30 draw this, Mr. Chairman.



1 MR. HANSARD: I don't think the Kefauver  
2 report makes much evidence here and I don't think what  
3 someone has taken out of it adds to it, and he said it does  
4 not change his presentation anyway.

5 THE CHAIRMAN: I have been puzzled as to how  
6 much weight we could give to it.

7 MR. FRAWLEY: I am overjoyed that my friend,  
8 Mr. Hansard, agrees with me.

9 MR. HANSARD: I thought for a while I dis-  
10 agreed with you, you were so cross with me earlier.

11 THE CHAIRMAN: You don't wish to proceed  
12 with it? I would think that we will not gain very much  
13 from it.

14 MR. CONDER: The offer on my part, Mr.  
15 Chairman, was merely to further strengthen the examples  
16 that we had in our brief on the premise that certain similar  
17 tables were picked out from the Kefauver exhibit in the  
18 Green Book. It is neither here nor there. It would merely  
19 strengthen our position with several other examples of  
20 what we have shown in our book. We are quite prepared to  
21 withdraw the offer.

22 THE CHAIRMAN: I think it had better be  
23 withdrawn unless you want to give us the accurate Kefauver  
24 reference, and even then it is material in another enquiry.

25 MR. HUME: I suspect Mr. MacLeod has probably  
26 got all this information, anyway, these exhibits and so on.  
27 I think we had better forget it.

28 MR. MACLEOD: It has become available since  
29 the Green Book was prepared. It is a subsequent publication.

30 THE CHAIRMAN: On counsel's suggestion we





1 will drop it.

2 MR. MacLEOD: On page 30 of your brief  
3 about a third of the way down the page, you say:

4 "1. Most raw materials must be imported  
5 from the United States and other nations,  
6 at a cost of anywhere from 15 to 20 per cent  
7 more than that paid by the United States  
8 manufacturer for the same material. The  
9 same applies to manufacturing equipment."

10 Is that consistent with other statements that drugs are  
11 much higher in other countries that you get raw material,  
12 in Italy, Holland, England, cheaper than in the United  
13 States?

14 MR. HUME: It is not confined to the United  
15 States, Mr. MacLeod. With respect it is "materials must  
16 be imported from the United States and other nations".

17 MR. MacLEOD: The suggestion is "Most raw  
18 materials must be imported from the United States and other  
19 nations at a cost of anywhere from 15 to 20 per cent more  
20 than that paid by the United States manufacturer for the  
21 same material."

22 I take it from that, that you imply that  
23 when the Canadian manufacturer goes to buy a drug or raw  
24 material, he has to pay 15 or 20 per cent more than the  
25 United States manufacturer for the same material.

26 MR. CONDER: Yes.

27

28

29

30



MT/dpw

1 MR. MACLEOD: So that if that is correct  
2 there are no other sources for drugs in the world that  
3 are cheaper than the United States?

4 MR. CONDER: No, I wouldn't say that. It  
5 depends on where - these enumerative paragraphs are an  
6 attempt to explain the difference between manufacturing  
7 in Canada and manufacturing in the United States.

8 MR. MACLEOD: Yes.

9 MR. CONDER: This is merely used to show  
10 that our Canadian companies must pay more than paid by  
11 U.S. manufacturers for the same materials.

12 MR. MACLEOD: So that in respect of the  
13 raw materials, and the basic drugs would be one raw  
14 material, a fairly important one, your contention is that  
15 the Canadian manufacturer pays 15 to 20% more than the  
16 U.S. manufacturer?

17 MR. CONDER: Yes, it would fall within  
18 that range. Mind you, this is a very general statement  
19 without going through all the tariff and duty importing  
20 structures, and working out a complete and very lengthy  
21 table. It would cost about that.

22 MR. MACLEOD: Yes, I am not arguing with  
23 you, Mr. Conder. I am just trying to get what you mean.

24 THE CHAIRMAN: If you could pin it down to  
25 one particular circumstance. One particular drug.  
26 Suppose the source from which the basic drug is obtained  
27 is Denmark. Can the United States manufacturer get that  
28 basic drug from Denmark at a price or cost of 15 to 20%  
29 less than the Canadian manufacturer? Is that what the  
30 statement means in part?



1 MR. CONDER: I would imagine it could apply  
2 in part there. I am not sure of the set-up between the  
3 United States and other countries and the inter-relation-  
4 ship of purchasing.

5 THE CHAIRMAN: I know the full meaning does  
6 not apply to drugs which Canadians import from the United  
7 States.

8 MR. CONDER: Yes.

9 THE CHAIRMAN: But the sentence appears to  
10 cover this other situation as well, and I am wondering if  
11 that is what is meant.

12 MR. CONDER: I believe the situation would  
13 be primarily this, Mr. Chairman, that the United States  
14 company generally is not merely, in many cases, a pure  
15 pharmaceutical manufacturer. In a number of cases he is  
16 also a primary producer as well, as well as a secondary  
17 manufacturer, so that he has his raw materials; he makes  
18 his raw materials, he then compounds them into dosage  
19 form.

20 For a Canadian company to purchase these  
21 raw materials from either that company or from another  
22 source, it would cost them anywhere from 15 to 20% more  
23 than that paid by the U.S. manufacturer.

24 MR. HUME: If we take out the words "and  
25 other nations", I think the thing would be quite clear.  
26 If the words "and other nations" were removed from the  
27 line, then it would read "Most raw materials must be  
28 imported from the U.S. at a cost of anywhere from 15 to  
29 20%..."

30 MR. WHITELEY: Except for this point: can



1 the witness make that statement that the only source of  
2 raw materials is the United States?

3 MR. HUME: He says most raw materials.

4 MR. WHITELEY: It is "must be imported".

5 MR. HUME: Must for economic reasons.

6 THE CHAIRMAN: In the form in which the  
7 sentence is cast it seems to me if the source of a parti-  
8 cular drug is outside of the United States, then the  
9 United States manufacturer can get that from another  
10 country laid down there at a cost of 20% less than the  
11 Canadian manufacturer.

12 MR. HUME: It depends on the tariff I  
13 suppose in the United States.

14 THE CHAIRMAN: I was wondering if there is  
15 any general picture of that kind.

16 MR. CONDER: It was in its very broad sense.  
17 It probably could be conceivable that the Canadian manu-  
18 facturer could either buy the product from the United  
19 States or buy it from some other country.

20 MR. MACLEOD: Frequent allegations were  
21 made about cheap foreign drugs. If it is a fact that it  
22 costs 15 to 20% more to buy a drug in Europe than in the  
23 United States, well then, the European drugs are not  
24 cheap.

25 MR. HUME: Aren't we talking about two  
26 different things? You mean cheap foreign raw materials;  
27 not drugs? Or do you mean cheap foreign dosage forms of  
28 pharmaceuticals? There is a very big difference between  
29 the two.

30 MR. MACLEOD: If Mr. Conder's statement is



1 correct, certainly it cannot apply but certainly there can  
2 be no question of the basic drug being cheaper. Basic  
3 raw material.

4 MR. HUME: I am sorry. I am concerned with  
5 your statement. You used the words "cheap foreign drugs".  
6 All I am asking you so that the witness may understand,  
7 are you referring to foreign drug in its dosage form,  
8 ready to be sold and distributed, or are you talking  
9 about cheap foreign raw materials which may  
10 eventually turn up as a pharmaceutical product?

11 MR. MACLEOD: Mr. Conder has stated "raw  
12 materials".

13 MR. HUME: I know what is here, but you  
14 said the oft-repeated allegation about cheap foreign  
15 drugs, and what I am asking you is what you mean by cheap  
16 foreign drugs. Are you talking about raw material?

17 MR. MACLEOD: Does your statement mean that  
18 raw materials are cheaper in the United States than in  
19 Europe; that is, basic drugs?

20 MR. CONDER: No, I would not necessarily  
21 say so. It is conceivable that they could be in certain  
22 lines, but we have no information on that.

23 MR. MACLEOD: Yes. Well then, you simply  
24 cannot make the statement then that most raw materials  
25 must be imported from the U.S. at a cost of anywhere from  
26 15 to 20% above prices in Canada - above what must be  
27 paid by the U.S. manufacturer?

28 MR. CONDER: I believe that the statement  
29 as we have it here, Mr. MacLeod, is a fair statement.

30 MR. MACLEOD: That is, to take a specific





1 example, a manufacturer can buy bulk penicillin in the  
2 United States for 15 to 20% cheaper than what the  
3 Canadian manufacturer would have to pay for the same  
4 penicillin?

5 MR. CONDER: Yes.

6 MR. MACLEOD: And you would say that applies  
7 to most drugs?

8 MR. CONDER: Most raw materials.

9 MR. MACLEOD: Most raw materials, yes. So  
10 then, restricting ourselves to raw materials, if your  
11 statement is correct then there are no cheap foreign  
12 sources, or if there are any, they are insignificant.

13 MR. HUME: United States is a foreign country.

14 MR. MACLEOD: Other sources.

15 THE CHAIRMAN: Apparently in this industry  
16 the United States and Canada are not foreign countries  
17 with respect to each other.

18 MR. FRAWLEY: With respect to the pharma-  
19 ceutical companies the witness can't tell us whether they  
20 are wholly-owned or not.

21 MR. MACLEOD: To avoid a long discussion,  
22 my use of "foreign" is probably incorrect. It was to  
23 deal with Europe, Japan; any source like that. You  
24 think that as far as basic drugs are concerned, if a  
25 Canadian manufacturer wants to buy them he will pay 15  
26 or 20% more in Europe or in other parts of the world  
27 than a manufacturer in the United States will pay in his  
28 own country?

29 MR. CONDER: It depends on where the product  
30 is made and where the product is held. We are referring



1 here to products which may be on the basis of comparison,  
2 products which are made in the United States and those  
3 made in Canada. Because a U.S. manufacturer does have a  
4 primary source of raw materials at hand, his costs are  
5 invariably from 15 to 20% lower than those of the compa-  
6 rable Canadian company here who does not have a source  
7 of primary supply at hand.

8 MR. MACLEOD: So that then there is no such  
2 9 thing as a Canadian manufacturer going to Europe and  
10 getting drugs cheaper than a United States manufacturer  
11 can get them in the United States?

12 MR. HUME: You mean raw material there?

13 MR. MACLEOD: Raw material.

14 MR. CONDER: I imagine that could be the  
15 case.

16 MR. MACLEOD: In your view it would be an  
17 exceptional situation.

18 MR. CONDER: An exceptional situation. In  
19 this area where the company in the United States is  
20 manufacturing a product, it has possibly its own source  
21 of primary supply and it would most definitely not go  
22 abroad for it. It would have it right there at hand.

23 MR. MACLEOD: On what do you base your  
24 information that the United States manufacturer can buy  
25 so much cheaper?

26 MR. CONDER: I asked a number of companies  
27 and received answers.

28 MR. MACLEOD: Did you explore with them  
29 whether they were in fact buying from parent companies in  
30 the United States or whether they had gone into the world



1 market and attempted to obtain the best prices?

2 MR. CONDER: No. I put the question to them  
3 pretty much the way it appears here.

4 MR. MACLEOD: This could very well be true  
5 in the case of the United States subsidiaries who are,  
6 as a matter of company policy, buying from their American  
7 counterpart, but it would not necessarily reflect the  
8 economics of the world market?

9 MR. CONDER: No, it could not affect econo-  
10 mics in the world market, but it might also apply on  
11 this basis: the U.S. manufacturer might conceivably,  
12 because he is using a larger amount of raw materials,  
13 be able to purchase - and I say conceivably - might be  
14 able to purchase these raw materials at a lower price in  
15 the United States than a Canadian company could purchase  
16 the much smaller amount of raw materials it would need  
17 from a foreign source. I say conceivably because it is  
18 strictly a speculative statement.

19 MR. MACLEOD: I think that statement must  
20 be acceptable.

21 MR. CONDER: I would agree with you on  
22 that. Generally it is a true statement as it appears,  
23 but there can be considerable variations.

24 MR. WHITELEY: Does your statement mean  
25 anything more than that duty and import in the United States  
26 range from 15 to 20%?

27 MR. CONDER: Just about that.

28 MR. MACLEOD: If it means only that, if it  
29 means that the Canadian manufacturer could buy at the  
30 same price as the American manufacturer in the United



1 States, this business of primary supply and so on has no  
2 application.

3 MR. CONDER: Why do you say that, Mr.  
4 MacLeod?

5 MR. MACLEOD: The only difference you have  
6 indicated is the duty.

7 MR. HUME: That is part of the cost to the  
8 Canadian manufacturer. There is your 15 to 20%.

9 MR. MACLEOD: I thought it was suggested  
10 that the American manufacturer, because of his integrated  
11 operations, had a lower cost than the Canadian manufacturer  
12 that went into the American market to buy them, and if  
13 that is the situation, the difference should be consi-  
14 derably more than the duty because you have to add duty  
15 on top of that.

16 MR. CONDER: That is true. We don't say  
17 whether it is duty or otherwise. We just make the state-  
18 ment "Cost of anywhere from 15 to 20%", and this is based  
19 on statements given to me by a number of our companies.

20 MR. MACLEOD: Can you give any estimate of  
21 the practical application of paragraph 2? That is, how  
22 is that fact reflected in the preparation of the product?  
23 Is it simply a question of economies of scale?

24 MR. CONDER: Economies of scale, and as I  
25 understand, Mr. Thompson pointed out before this Commission  
26 a comparison of the large-scale manufacturing operations  
27 in the United States, and the mechanization which results  
28 from that; based on that type of operation there would be  
29 a considerable saving at the per unit end of a product,  
30 based on the further premise that it is more economical



1 as a rule to manufacture a million items than it is to  
2 manufacture, say, ten thousand items.

3 MR. MACLEOD: Yes. I suppose you could  
4 not possibly indicate the application of that to different  
5 drug costs?

6 MR. CONDER: No, I am afraid not.

7 MR. MACLEOD: Has your Association made any  
8 comparison on the higher costs per unit which do result  
9 in Canada because of the factor you have mentioned?

10 MR. CONDER: No, we have not gone into a  
11 general study of that.

12 MR. MACLEOD: I think the Chairman suggested  
13 to you the other day there might be factors working the  
14 other way making a lower cost in Canada.

15 MR. CONDER: Actually in a manufacturing  
16 operation we are putting down here different elements  
17 which may go into this manufacturing operation. The cost  
18 of mass-production techniques is considerably less on a  
19 per unit basis than other costs.

20 In addition to that, for example, in a  
21 country you may have a low cost on the labour end, depen-  
22 ding on the amount of labour that goes into a product.  
23 This might be in essence a compensating factor, but you  
24 have to take each of these stages together to determine  
25 what the end result may be.

26 MR. MACLEOD: Perhaps we are talking of  
27 imponderables here that we cannot solve, so we will go on  
28 to something else.

29 THE CHAIRMAN: If you have finished with  
30 that particular heading, Mr. MacLeod, I think we will





1 adjourn.

2 MR. MACLEOD: Fine.

3 MR. FRAWLEY: Mr. Chairman, I may not be  
4 here this afternoon. Is it understood on Monday morning  
5 the Commission will sit in Toronto and receive the  
6 Canadian Pharmaceutical brief?

7 THE CHAIRMAN: We are proposing to sit here  
8 Monday. I don't know how far we will get with the present  
9 matter this afternoon. We hope we will conclude at a  
10 reasonable hour this afternoon. The Pharmaceutical  
11 Association suggested they would be ready at that time.  
12 We have one or two that would like to go on Tuesday.

13 By the way, I omitted one this morning. I  
14 think we will need to have a time, probably on Tuesday.  
15 That is the Canadian Society of Hospital Pharmacists.

16 Is there anybody here for them at the  
17 present moment? There was somebody here the other day.

18 MR. COOK: Mr. McNab, the President, was  
19 here on Monday.

20 THE CHAIRMAN: Yes. I understood they  
21 wanted to make some presentations.

22 MR. COOK: That was my understanding. I  
23 will make inquiries. Was it your suggestion they should  
24 be ready this afternoon?

25 THE CHAIRMAN: No. I am inclined to think  
26 we will conclude with the Manufacturers' representations  
27 this afternoon rather than start something that we cannot  
28 go further with. Adjourn until 2.15.

29  
30 --- Luncheon adjournment.



AA/MR/hm 1 ---Upon resuming at 2:30

2 THE CHAIRMAN: Mr. MacLeod?

3 MR. MacLEOD: Page 31, Mr. Conder, you have

4 a statement on the high degree of risk in the industry.

5 Up to the present hasn't that been more theoretical than

6 real? Hasn't the fact been that a greater majority of

7 companies have been able to bring out new products, successful

8 products? There are many examples of that. Now I suggest

9 to you there are very few examples of a company failing

10 or suffering substantial loss because of its product going

11 out of fashion.

12 MR. CONDER: I understand Mr. MacLeod, that

13 there have been many examples of products which have been

14 replaced to one degree or another over the years. That is

15 the point on risk that is mentioned or used in our brief.

16 It is more from the chemical viewpoint than -- I would

17 actually prefer Dr. Dixon to comment on this -- than from

18 the economic aspect of the usage.

19 MR. MacLEOD: On page 38 you question a

20 comment in the Green Book "Research in Canada appears to

21 be regarded more and more as a responsibility of govern-

22 ment and of those private organizations interested in

23 particular diseases."

24 Perhaps we are not too far apart on this.

25 It is the Director's suggestion that the views of the

26 Farquharson Committee represent the opinion that infusion

27 of public money into research was extremely urgent. In

28 that sense we suggest that it is coming to be believed that

29 Government does have an increasing responsibility in this

30 field.



1 MR. CONDER: I would agree with that  
2 certainly, sir, in that context as such.

3 MR. MacLEOD: And in point of fact the re-  
4 search carried on by Government for example in the United  
5 States is extremely extensive is it not?

6 MR. CONDER: It is very extensive.

7 MR. MacLEOD: The impression is sometimes  
8 created, perhaps unwittingly, that most of the research in  
9 this field is done by the pharmaceutical companies. No  
10 one would wish to belittle their contribution but it is  
11 nevertheless the fact that there are other contributors  
12 in the field.

13 MR. CONDER: We would certainly not wish  
14 to belittle any other contributor in the field of pharma-  
15 ceutical research Mr. MacLeod. Our sole attempt here was  
16 not to belittle these other groups. It is vitally im-  
17 portant that the Government show and take an active interest  
18 in the field of pharmaceutical research and in general  
19 medical research.

20 Our sole desire here was to attempt to give  
21 an explanation of the role of industry in this respect.

22 MR. MacLEOD: On page 40 you take some  
23 exception to the figures of the Green Book.

24 MR. CONDER: Again I would state, Mr.  
25 MacLeod, that we are probably not too far apart in this  
26 area.

27 MR. MacLEOD: Yes. I was wondering, for  
28 instance, I believe Smith, Kline and French introduced a  
29 new product, Orono, or something like that, and sold it  
30 under a branch of the organization known as Franklin



1 Laboratories.

2 MR. CONDER: Unfortunately, I don't know  
3 the product you are referring to. I believe Franklin  
4 Laboratories is a proprietary division of S.K.F.

5 MR. MacLEOD: Are you aware that this  
6 particular product was introduced with a great deal of  
7 fanfare, heavy T.V. publicity. For instance, you have  
8 Larry Henderson in this area who plugged it consistently  
9 for a time.

10 MR. CONDER: I have heard mention of it,  
11 but as I say, I know nothing about the product at all.

12 MR. MacLEOD: The question I was going to  
13 put to you was: Do you think it is fair to exclude  
14 proprietary medicines simply because they are proprietary  
15 medicines from the burden of research? I take it that is  
16 what you have done here as one of the classes you have said  
17 that we should not count proprietary medicines. I would think  
18 that would be an example of a product where some research  
19 expenditures were involved.

20 MR. CONDER: I imagine there would be  
21 research expenditures involved in proprietary medicines  
22 but nowhere near to the extent that there would be involved  
23 in what we term ethical pharmaceutical research.

24 Certainly, the vast bulk of research being  
25 done by the industry is directly in the field of ethical  
26 pharmaceuticals. In some cases they will undertake  
27 research in certain areas in ethical pharmaceuticals which  
28 will produce results which may be beneficial to the  
29 proprietary medicines.

30 MR. MacLEOD: And in the case of at least



1 some chemicals, which is another class of sales which you  
2 would exclude, there are some of these chemicals that  
3 would have been produced by research and should bear their  
4 proportion of the burden, if any one is going to bear it?

5 MR. CONDER: Yes. I believe the research  
6 in chemicals in our industry is comparatively small in this  
7 connection because in using the breakdown of our sales  
8 dollar we specifically asked the very large chemical houses,  
9 chemical houses such as Cyanamid or Merck where a large  
10 percentage of their volume is in the chemical field, to  
11 exclude those chemicals from their total sales. As the  
12 result, you will have other companies which will have  
13 chemical sales but to a very small degree, and as the  
14 result their primary emphasis is placed on pharmaceuticals  
15 and the research is towards pharmaceuticals as such.

16 MR. MacLEOD: My only suggestion is it may  
17 not be completely accurate to do what you have done,  
18 exclude these sales. Conceivably some of them at least  
19 should bear some of the burden of the cost of research on  
20 any reasonable basis.

21 MR. CONDER: The problem would be to determine  
22 in what basis. In our survey we asked our companies  
23 specifically for the research expenditures in respect to  
24 pharmaceuticals.

25 MR. MacLEOD: Well, perhaps that is as far  
26 as we can take it. You would not, for instance, exclude  
27 from your figures the sales of penicillin 152 by Bristol  
28 to Beecham? That would be a sale of a chemical I would  
29 take it?

30 MR. CONDER: I honestly don't know on that





1 point, Mr. MacLeod, how that one would be handled in cur  
2 survey, or what the reporting company would state.

3 If the sale was from the U.K. company of  
4 Beecham, for example, to Bristol in this country, then the  
5 sale would not be carried in our records because we only  
6 carry the Canadian operations in our survey.

7 MR. MacLEOD: I am putting to you the case  
8 which is referred to in the Green Book of Bristol in Canada  
9 selling to Beecham of Canada.

10 MR. CONDER: We have attempted to sift this  
11 out in our survey where you may have a duplication of  
12 sales. In other words, it is known that some companies  
13 will do certain jobs on a processing nature, or sales  
14 nature to another company and if these companies all  
15 declared their sales, there would be a considerable dupli-  
16 cation on it. We have attempted to weed this part out. There  
17 is bound to be some of it included though in the sales.

18 THE CHAIRMAN: One statement you made a  
19 moment ago, you said that you had asked your members for  
20 their research expenditures in connection with pharmaceuticals.  
21 Now, are you limiting pharmaceuticals to ethical products?

22 MR. CONDER: To ethical products, yes, and  
23 that would probably be taken to include over the counter,  
24 so-called over the counter ethicals.

25 THE CHAIRMAN: Now I might have seen this  
26 somewhere, but I have forgotten it. What does O.T.C.  
27 stand for?

28 MR. CONDER: Over the counter.

29 THE CHAIRMAN: I should have heard it,  
30 shouldn't I.



1 MR. WHITELEY: Do these comments you are  
2 making refer to the survey which results are given on  
3 page 17?

4 MR. CONDER: No. My reference was to a  
5 special survey which was undertaken on research and develop-  
6 ment. This research and development figures that we are  
7 mentioning here, this is the result of a special survey  
8 undertaken for that purpose.

9 MR. HUME: Is that the one on page 42, Mr.  
10 Conder?

11 MR. CONDER: No, it is not page 42. Page  
12 37.

13 MR. MacLEOD: On page 45, about two-thirds  
14 of the way down the page you say "Furthermore, to make  
15 its name known to the profession, the company selling under  
16 generic name would have to advertise, but by so doing it  
17 would add to its cost and so lose its primary advantage of  
18 price."

19 Is that done to suggest that the main  
20 difference in cost between the generic manufacturer and  
21 the brand name manufacturer is in advertising cost?

22 MR. CONDER: No, not alone but it would  
23 certainly make a difference to the generic company by adding  
24 to his operating cost.

25 MR. MacLEOD: I think your statement is  
26 rather strong then in that it does, on its face, appear  
27 to suggest that advertising accounts for a considerable  
28 proportion of these differences in cost.

29 MR. CONDER: There are many points involved  
30 here. Probably it would be more explicit if I said this,



1 Mr. MacLeod: That when a company introduces -- after a  
2 company brings a product out from its laboratory and is  
3 ready to take the cloaks off that product and make it  
4 available to the market, it must then introduce this  
5 product and it costs a considerable amount of money to  
6 get this product prepared, to introduce it and to place  
7 it on the market.

8 Now this is a cost factor to the company  
9 initiating the product. A company coming along afterwards,  
10 a purely generic product company gains all the advantages  
11 of introduction by the initiator of this product.

12 Now, if you had these companies starting  
13 out, if we had a generic name system, as such, in effect,  
14 as of now, this would mean all companies, regardless,  
15 would be on the same basis in putting out a product.

16 MR. MacLEOD: Yes.

17 MR. CONDER: And they would all have to bear  
18 their proportionate share of the expense. In other words,  
19 they would then all be on a level insofar as the actual  
20 production market and other factors were concerned, in this  
21 country.

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PB/hm

1 THE CHAIRMAN: None of them would be able  
2 to get a free ride?

3 MR. CONDER: That is right, sir.

4 THE CHAIRMAN: I would have thought if a  
5 product is sold strictly under generic name and anybody  
6 can make it some of them might do advertising and other  
7 people might then get a free ride without much trouble.  
8 Wouldn't that be possible?

9 MR. CONDER: I imagine it would be possible,  
10 but the advantage wouldn't be as great.

11 THE CHAIRMAN: I would have thought it  
12 might be greater than the situation is now when under a  
13 patent name or trade name, operating under a patent  
14 increases expenses to attract a good deal of attention to  
15 the name and that helps to sell products once the reputation  
16 is established if you only have a generic name anybody  
17 could use there wouldn't be any expense.

18 MR. CONDER: That is true. The only  
19 advantage, you would have to advertise or make known the  
20 name of the company with the hope the physician would  
21 place it down, the name of the generic drug and the  
22 name of the company after it. If you had the straight  
23 generic operation right across the board, all companies  
24 selling under generic name, there is no doubt whatever  
25 much of the incentive that does exist now for the so-called  
26 smaller companies engaging in their field would disappear.

27 MR. MacLEOD: You say if all products could  
28 be sold under generic name this would tend to squeeze out  
29 the smaller companies and thus curtail competition in the  
30 industry.



1 MR. CONDER: I was using the term smaller  
2 companies much the same as it is used in the Green  
3 Book, in this context, that where you have a small company  
4 that is now in the market with a product.--it may be an  
5 importing company, for example, and if it is an importing  
6 company that is bringing a product over from a European  
7 source, for example, and placing it on the market in  
8 finished dosage form here in Canada, it has a small  
9 market as the result of the generic name itself. In other  
10 words that company selling under a trade name has considerable  
11 expense in an effort to maintain its trade name and to  
12 keep it before the medical profession. The generic name  
13 operator counts on the savings which may be realized in  
14 certain areas by selling through generic name to appeal  
15 to a certain group of doctors or hospitals to sell his  
16 products. He has an advantage primarily because he states  
17 it is by generic name and as a result of this generic  
18 name it may be sold to such doctors. If you have a uniform  
19 and complete generic system right across the board the  
20 larger companies would go into operation on generic name  
21 operations and conceivably might find there is no longer  
22 the incentive to maintain manufacturing plants here and  
23 that company may in turn start importing products and  
24 selling them under the generic name in Canada because there  
25 would be no advantage to be gained by continuing a  
26 manufacturing operation here. By virtue of the volume  
27 and the name of the company on the market there is no  
28 doubt whatever it would tend to squeeze out smaller companies  
29 that are in the field.

30 MR. MacLEOD: In your statement you mentioned





1 that the large company might start to import. Are you  
2 suggesting drugs are cheaper from foreign sources?

3 MR. CONDER: I believe that it is more  
4 economical to purchase drugs from certain other countries  
5 which possibly don't recognize patents than it would be  
6 to manufacture these drugs right in this country.

7 MR. MacLEOD: I thought we got it clear  
8 this morning in your view it is not cheaper to bring in  
9 the raw material from other countries?

10 MR. CONDER: No, it could be. It definitely  
11 is much cheaper to bring raw materials into the country  
12 than attempt to manufacture them here. That is why there  
13 is comparatively little manufacturing of raw materials  
14 here.

15 MR. MacLEOD: In your statement you say if  
16 all products could be sold under generic name it would  
17 tend to squeeze out the smaller companies and thus curtail  
18 competition in the industry. You are suggesting, I take  
19 it, if all products were sold under generic name the prices  
20 of the trade, of the present trade name brand products  
21 would be reduced to the level of the prices of the generic  
22 products.

23 MR. CONDER: On those terms, you have to  
24 carry it through to its logical conclusion, Mr. MacLeod,  
25 if you are bringing a generic name system into effect  
26 and the manufacturer in Canada, which might conceivably  
27 be a subsidiary of a foreign corporation -- I believe it  
28 is recognized we have quite a few of those in Canada --  
29 this company might feel it is no longer worthwhile to  
30 maintain their establishments here and as a result it may



1 feel it should become an importer of products in dosage  
2 form and sell it on par with the pure generic operator  
3 that is already in the country.

4 MR. MacLEOD: Some of the present generic  
5 houses make the raw material and manufacture, do they not?

6 MR. CONDER: I believe so.

7 MR. MacLEOD: In the sense you would define  
8 manufacture.

9 MR. CONDER: Yes, that is correct. I don't  
10 know what number. I think it is mentioned it is the case.

11 MR. MacLEOD: Yes. Well, do you think that  
12 generic names, the use of generic names would bring the  
13 prices of the trade name brand manufacturers down to that  
14 level?

15 MR. CONDER: It is a very difficult thing  
16 to say, Mr. MacLeod, because economically a product must  
17 find, eventually, its own price level with everything being  
18 the same or equal.

19 MR. MacLEOD: I think my question about  
20 that sentence would be along the same lines as the  
21 Chairman was suggesting to you, surely the competitive  
22 advantage is much greater for the larger firm under the  
23 brand name system than under the generic name system.

24 MR. CONDER: That may be it is, that the  
25 advantages which have accrued to smaller companies who  
26 have become or entered the purely generic operation have  
27 been the direct result of the fact that the other companies  
28 are selling under trade names, so that the advantage has  
29 worked both ways.

30 MR. MacLEOD: The direct result of the fact



1 that the other companies are selling under trade names or  
2 the direct result of the fact the other companies are  
3 selling at higher prices?

4 MR. CONDER: There is no doubt whatever that  
5 price is an advantage on it.

6 THE CHAIRMAN: Is there any other reason  
7 why people buy by generic name rather than established  
8 trade names other than they can, at least in some instances,  
9 obtain drugs under the generic name at a lower price?

10 MR. CONDER: The primary reason for selling  
11 under generic name or buying under generic name is one of  
12 price.

13 THE CHAIRMAN: That is what I thought.

14 MR. MacLEOD: Now, there is some discussion  
15 here about brand and generic names and I would like to  
16 get from you specifically what your Association objects  
17 to in the selling of drugs under generic names. Regardless  
18 of where the material comes from, whether foreign or  
19 manufactured in Canada provided the final preparation  
20 is carried out in Canada you have no objection to that.

21 MR. HUME: I wonder whether this position  
22 is not set out in page 46 as completely and precisely as  
23 you can ask for, "The general tenor of our Association's  
24 position in respect to generic names..." -- et cetera.  
25 Do you want amplification of that as to what the position  
26 is?

27 MR. MacLEOD: Yes, I think I do. I want  
28 to get clear precisely what relation the word foreign has  
29 to any condemnation of generic name drugs which may be  
30 made?



1 MR. CONDER: I don't believe I am quite  
2 with you on this point, Mr. MacLeod. We are not condemning  
3 foreign drugs as such in this case. We don't believe in  
4 foreign drugs, naturally, because we are representing  
5 manufacturers in this country.

6 MR. MacLEOD: Yes. Foreign as such has  
7 nothing to do with quality? I mean you don't class foreign  
8 drugs as inferior?

9 MR. CONDER: You are particularly interested  
10 in our stand on whether the generic drugs or any drugs  
11 as a matter of fact would be acceptable to us? Is this  
12 correct, sir, on the quality control, testing and other  
13 factors involved in this?

14 MR. MacLEOD: Yes, I am trying to pinpoint  
15 just exactly what your objection to generic drugs is  
16 because as is mentioned in the Green Book, analyzing the  
17 various criticisms it is very difficult to pinpoint exactly,  
18 one time it is an objection on the basis it is foreign,  
19 another time that it is cut-rate, another that it is  
20 the pirating of design of large companies, another time  
21 it is inferior quality?

22 MR. CONDER: No sir, a lot of our companies,  
23 of course, manufacture drugs under generic names, as we  
24 mentioned in our brief. I don't think our companies would  
25 like us to make statements of that nature about all  
26 generic drugs by any stretch of the imagination.

27 We say this: Firstly, we do oppose the  
28 thought that all drugs with the same generic name are  
29 absolutely equivalent. That is the first stand on this.  
30 When it comes down to the manufacture of drugs and supply-



1 ing drugs to the manufacturer importing in Canada our  
2 stand is purely this: Before any medication is placed on  
3 the market in Canada today that medication should be  
4 checked or come from a source which we are reasonably  
5 certain has complied with the usual manufacturing  
6 techniques insofar as the quality control procedures are  
7 concerned. This doesn't mean you take a product in dosage  
8 form and then have the product assayed to determine the  
9 contents of it because this is only the final stage of  
10 what can often be long and complex quality control  
11 work. We believe then the raw materials brought in should  
12 be checked and approved and evaluated by the company  
13 turning these products out. We then believe that the  
14 company processing this product into its final  
15 dosage form, during its manufacturing process the actual  
16 quality control should be done at that time, should be  
17 built right into the product so when it comes to the final  
18 assay at the end it is a mere check of the final product to  
19 confirm all the quality control work which has been built  
20 into the product during its stage of manufacture.

21 MR. MacLEOD: Yes.

22 MR. CONDER: This is not required on  
23 pharmaceuticals at the present time. We believe that many  
24 of the companies selling under trade name in Canada do  
25 that right now. They have a name to protect with the  
26 medical profession because they are selling under trade  
27 name and as the result they are going to ensure that they  
28 have this so-called batch consistency throughout the  
29 lifetime of this particular product so that every produc-  
30 tion turns out exactly the same as the one that preceded





1 it. If the companies feel it is good for them to do this  
2 and believe that this is in their best interest to do  
3 so there can be no doubt whatever, it is certainly in the  
4 best interest of the public and the profession. We  
5 definitely believe all companies, regardless of whether  
6 they are manufacturing here or importing here should  
7 be required to certify that drugs meet this requirement  
8 and have been processed in accordance with these requirements.

9 MR. MacLEOD: Yes. Well, arising out of  
10 the considerations that you named does your Association  
11 take the stand that trade name, brand name products are  
12 superior to generic name products?

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1 MR. CONDER: I believe that may be taken as  
2 a statement in fact in this respect, that the company  
3 which introduces a new product and puts it on the market  
4 first, will often be the company which produces all the  
5 work leading to the development of this product. Someone  
6 may come along and imitate that product.

7 The first company that does the initial  
8 studies, development, and is continually researching  
9 that product to try and find some improvement, some modi-  
10 fication of the product, to make it a superior product,  
11 it would certainly appear as a personal opinion, and it  
12 would depend upon the product entirely, but it would  
13 appear that such a product by the originator could be  
14 a superior product.

15 MR. MACLEOD: Yes.

16 MR. CONDER: By the same token, the imitator  
17 coming along might conceivably have something in the  
18 product which might vary to a certain extent. It may be  
19 in the process of the manufacturing, the compounding of  
20 the materials, but it may have a slight variance from  
21 the first product.

22 A doctor is used to having an experience  
23 with patients based on the first product, and then takes  
24 the second product, and on that second experience he may  
25 not feel the second product is as good because he knows  
26 from experience what the first product is doing for his  
27 patient, and he is not getting the same reaction from the  
28 second one.

29 THE CHAIRMAN: I suppose it is possible that  
30 these variations might actually produce an improvement



1 in the second product.

2 MR. CONDER: That is precisely so, sir, but  
3 only if that company does have the research and develop-  
4 ment facilities with which to produce a better product.

5 THE CHAIRMAN: Yes, most likely that would  
6 be necessary.

7 MR. CONDER: Yes.

8 MR. MACLEOD: We may be spending a lot of  
9 time on this, Mr. Conder, but I was trying to get a  
10 clear answer from you. You have given me a number of  
11 reasons, and I was trying to get a clear answer from you  
12 whether it is the position of your Association that  
13 generic name products are inferior to brand name products.

14 MR. HUME: That is hardly a fair question  
15 because it is such a general thing. It is the same as  
16 saying a Canadian-made automobile is better than an  
17 American-made automobile. Some are and some are not,  
18 and surely you can't expect an answer to a broad general  
19 question like that.

20 MR. MACLEOD: I am not asking him to solve  
21 the question, but just to tell us the position of his  
22 Association on the question.

23 MR. HUME: The brief states it.

24 MR. CONDER: Our position will be precisely  
25 as Mr. Hume has stated, Mr. MacLeod, that obviously some  
26 are and some are not. It is difficult to say. We show  
27 here quite a number of companies that do manufacture a  
28 considerable number of products under generic name.

29 MR. MACLEOD: Yes.

30 MR. HUME: Excuse me. May I read three



1 lines and see whether this does not answer the question.  
2 I am reading from page 46. It is adopted by the Associa-  
3 tion's brief as being the general tenor of their position:

4 "While I know of no responsible person  
5 associated with any pharmaceutical company who is critical  
6 of generic names for drugs, there is great opposition to  
7 the idea of equivalency of all drugs with the same generic  
8 name".

9 That surely I think sums up the position in  
10 about as few words as you can imagine.

11 MR. MACLEOD: Perhaps, but it does not sum  
12 it up for me.

13 MR. HUME: If I can help then, I want to  
14 make sure we understand your question. Are you asking  
15 Mr. Conder whether or not there are times when a generic-  
16 named drug is better than a brand name drug?

17 MR. MACLEOD: No, I am asking him if he  
18 takes the position that brand name drugs are superior to  
19 drugs sold under the generic name.

20 MR. HUME: Perhaps he can answer it.

21 MR. CONDER: As a general statement as such,  
22 we could not make - I should say this - we could not make  
23 a general statement as to whether brand name drugs are  
24 superior to generic name drugs because undoubtedly there  
25 are some drugs sold under a trade name which may concei-  
26 vably not be quite as good as there are bound to be drugs  
27 which are sold under a generic name which are not quite  
28 as good. I believe Dr. Morrell brought this point out  
29 in one of his statements.

30 MR. MACLEOD: Yes.



1 MR. CONDER: It would depend primarily upon  
2 the product and on the respective merits of the two  
3 products that are in the same area.

4 MR. MACLEOD: The term "generic" itself  
5 carries no connotation of inferiority.

6 MR. CONDER: All products carry the generic  
7 name on the label.

8 MR. MACLEOD: But the admission of the  
9 brand name - let me put it that way - the admission of  
10 the brand name on the label does not mean that the product  
11 is inferior.

12 MR. CONDER: No I would not say it would.

13 MR. HUME: It means you don't know where it  
14 came from, but it is not necessarily inferior.

15 MR. MACLEOD: It is not necessarily inferior  
16 because the raw material in the drug originated in a  
17 foreign country.

18 THE CHAIRMAN: You may know where it came  
19 from if it has the name of the manufacturer on it, even  
20 though he does not use the trade name.

21 MR. HUME: There is no magic in a trade name.  
22 It is merely a label, and whether it is a manufacturer's  
23 name, or a coin word - and I am using "trade name" in  
24 that sense - I am taking Mr. MacLeod's question as meaning  
25 purely a generic name. Is that the purport of your ques-  
26 tion?

27 MR. MACLEOD: Yes.

28 THE CHAIRMAN: That is without reference  
29 to any particular manufacturer?

30 MR. HUME: Yes. Once you refer to a





1 manufacturer, it is my respectful submission that you are  
2 in the equivalent of the brand name.

3 THE CHAIRMAN: If a manufacturer sold a drug  
4 under a trade name and later sold it without a trade name,  
5 it would still be the same manufacturer. It is unlikely,  
6 but it is not impossible.

7 MR. HUME: It is quite possible, and it  
8 could happen, in which case, in the former case, you  
9 would not know where it came from.

10 THE CHAIRMAN: A manufacturer could have  
11 the name of his company on it and use the trade name for  
12 some product, and not use it on another. It is very  
13 unlikely.

14 MR. HUME: Even if it happened, the manufac-  
15 turer's name would be on it. The trade name is an indica-  
16 tion to the consumer. It is a convenient name, because  
17 one seeing a trade name can quickly identify the product.

18 THE CHAIRMAN: I would be inclined to think  
19 that the trade name of the drug often means more to the  
20 purchaser than the name of the particular manufacturer.  
21 I can remember hearing from many sources that the trade  
22 name "Aureomycin", long before I knew that it was Cyana-  
23 mid's product.

24 MR. HUME: Yes sir, but does it mean more  
25 to the man who makes the selection, the doctor? Surely  
26 it cannot mean more to him. He does not care whether the  
27 name is "Aureomycin" or some corny name that I might  
28 think up. All he wants to know is, is it a reputable  
29 manufacturer who is making it, I submit.

30 MR. MACLEOD: Finally on this point, it is



1 not the position of the Association, as I understand it,  
2 that the smallness in the size of the manufacturer makes  
3 a difference.

4 MR. CONDER: I am sorry I did not get the  
5 last part of that.

6 MR. MACLEOD: ----that the smallness in  
7 the size of the manufacturer makes any difference.

8 MR. CONDER: No sir, we believe it is the  
9 reputation of the manufacturer that counts, and we do have  
10 quite a few small companies in our Association.

11 MR. MACLEOD: But you regard their quality  
12 control procedures as adequate and so on?

13 MR. CONDER: Yes sir, we do.

2 14 MR. MACLEOD: So that smallness itself  
15 again is no criterion?

16 MR. CONDER: None whatever.

17 MR. MACLEOD: And the fact that a product  
18 is put out under a generic name by a small company would  
19 not mean it was inferior to the same product put out  
20 under a brand name by a large company?

21 MR. CONDER: Not necessarily.

22 MR. MACLEOD: I am just trying to get the  
23 position of the Association clear.

24 There was some material in your brief on  
25 sampling and direct mailing. I just mention in passing  
26 that the Director did secure the sample for a six-month  
27 period of all the mailings done by certain firms, and  
28 those were before the Commission, and I don't think we  
29 need go into that here.

30 On the sampling, I must direct your



1 attention to something we were looking at before lunch  
2 on page 29 of the Green Book, where an official of the  
3 company whose letter is quoted says, "This high cost of  
4 samples is not reflected in any way in the 'cost of manu-  
5 facturing and packaging' which you have required---"  
6 "---it is, however, an essential cost of doing business  
7 and is a principal factor responsible for the fact that  
8 'sales expense' of this particular company has ranged  
9 from 32.2% to 42.5% of its total sales during the past  
10 five years".

11 So in the case of that company, at least  
12 based on the information set out in the letter from the  
13 company, sampling would have been a substantial cost.

14 MR. CONDER: It would appear to be, yes.

15 MR. MACLEOD: Now, just a word about patents.  
16 If you look at the list on pages 34 to 37 of the Green  
17 Book, if we consider Ayerst as being the American subsi-  
18 diary of the American Home Products Limited, then ---

19 MR. HUME: Do you mean the Canadian subsi-  
20 diary or the American subsidiary?

21 THE CHAIRMAN: You meant the Canadian subsi-  
22 diary. You said the American subsidiary.

23 MR. MACLEOD: It is the Canadian subsidiary  
24 of the American Home Products Limited, and including  
25 patents to those particular firms, it would appear that  
26 as I make it, there are only four firms, four patents  
27 listed as having been issued to Canadian firms unless I  
28 have missed some. That is, there were three to the Gover-  
29 nors of the University of Toronto in respect to penicillin  
30 and one to the Frosst Company. This would appear to



1 indicate that in this particular field at least the large  
2 majority of patents are held by American firms.

3 Does the survey which you made and which is  
4 reported in your brief in respect of compulsory licencing  
5 cover licencing arranged between or among American  
6 principals.

7 MR. CONDER: No it doesn't.

8 MR. WHITELEY: How can you say that?

9 MR. CONDER: We ask them specifically.

10 MR. HUME: Do you mean American principals  
11 per se, or between American principals on the one hand  
12 and Canadian on the other?

13 MR. MACLEOD: Either way. What I am parti-  
14 cularly interested in would be any arrangements of that  
15 sort which would affect the sale of the drug in Canada.  
16 Have you attempted to include the patent arrangements,  
17 the patent licencing arrangements, among American firms  
18 which would affect the sale of the drugs by their subsi-  
19 diaries in Canada?

20 MR. CONDER: This could very well be  
21 included in here, but we asked specifically for the infor-  
22 mation based on the granting of a voluntary licence to  
23 another company.

24 MR. HUME: I think Mr. Carignan brought in  
25 this point yesterday, and the answer was no.

26 THE CHAIRMAN: Mr. Conder, would you have  
27 any information as to arrangements in the United States  
28 between American manufacturers and their effect upon  
29 operations in Canada?

30 MR. CONDER: No sir, we have done no study



1 on that.

EMT/dpw 2 MR. HANSARD: There are no assumptions  
3 surely?

4 THE CHAIRMAN: I am not suggesting there  
5 are. I am asking if he would know of any.

6 MR. HANSARD: He said he hadn't made any  
7 study.

8 MR. FRAWLEY: It is alleged in New York  
9 there are such.

10 THE CHAIRMAN: We have no information one  
11 way or the other.

12 MR. MACLEOD: I am sorry, Mr. Chairman. I  
13 thought I had this marked, but I don't appear to have.

14 MR. WHITELEY: It would be well to get on  
15 the record the actual nature of the inquiries that were  
16 addressed to the companies.

17 MR. CONDER: Yes. I asked the companies --

18 MR. WHITELEY: Perhaps you might furnish  
19 the Commission with the actual wording so that we will  
20 have it down.

21 MR. HUME: Have you got it with you now?

22 MR. CONDER: No.

23 THE CHAIRMAN: Did you put it in the form  
24 of a questionnaire?

25 MR. CONDER: Yes.

26 THE CHAIRMAN: Perhaps we might have a  
27 blank questionnaire.

28 MR. CONDER: Yes, all right, that is fine.

29 MR. HUME: While Mr. MacLeod is looking  
30 for his material, Mr. Chairman, perhaps it is pertinent





1 at this time to point out Section 41 of the Patent Act  
2 provides for the preparation or production of substances by chemi-  
3 processes and intended for food or medicine. The provi-  
4 sion in Sub-section 3 relating to compulsory licences  
5 does not necessarily limit the grantee of the licence to  
6 any particular commitment to manufacture in Canada,  
7 although it is my understanding that this is the view of  
8 the Commissioner of Patents.

9           The wording of the Act I think is significant  
10 in that it begins "The Commissioner shall, unless he sees  
11 good reason to the contrary, grant to any person applying  
12 for the same, a licence limited to the use of the inven-  
13 tion for the purposes of the preparation or production of  
14 food or medicine", but not otherwise.

15           There is no geographical limitation or other  
16 limitation, so it is perhaps of some significance that  
17 the Statute at least merely provides a broad general compul-  
18 sory licencing, and there are no limitations but it is  
19 merely as the Commissioner - unless he sees good reason  
20 to the contrary.

21           MR. WHITELEY: There is provision in the  
22 Patent Act stating the purpose of the granting of the  
23 patent.

24           MR. HUME: Yes, but the compulsory licence  
25 does not necessarily, in my submission under these words,  
26 have to apply to a process being in fact used in Canada.

27           MR. WHITELEY: The Commissioner may grant  
28 a patent. It should be under the same footing.

29           MR. HUME: Well he might, but he is not so  
30 restricted under the Act, and I understand he does.



1 I merely pointed out that in the Statute the wording of  
2 the section provides there shall be this compulsory licence  
3 for food and drugs. This is not true of other goods.

4 It is my submission in a proper case the  
5 Commissioner of Patents could, if for example an article  
6 was being produced by a patented process elsewhere,  
7 still give a compulsory licence and permit importation.

8 THE CHAIRMAN: Granting of a patent itself,  
9 used within the territory of Canada. A licence under  
10 that could hardly be broader territorially than the patent  
11 itself.

12 MR. HANSARD: Patents are all territorial.  
13 There has to be an American and a Canadian one.

14 THE CHAIRMAN: Yes. The Canadian patent is  
15 limited to Canada. I would have thought the granting of  
16 a licence under the Canadian Act could not be broader  
17 territorially than the patent itself.

18 MR. MACLEOD: It is interesting to note  
19 just within the last few weeks in the Canadian Patent  
20 Reports which reports on Canadian patent cases, and also  
21 contains comments from lawyers, there is an article  
22 completely reviewing the whole history of this section,  
23 and supporting Mr. Hume's view that the Commissioner was  
24 wrong in the particular case which was mentioned here  
25 that there could not be any applicant licenced to import  
26 - the case was a little more complicated than that.

27 MR. HUME: I would hate to have that labelled  
28 as my view. My purpose was merely to point out to the  
29 Commission for whatever assistance that this is, that the  
30 wording is there, and so far as I am aware, this section



1 has not been specifically interpreted by the Exchequer  
2 Court. The section goes on to indicate that the manufac-  
3 turer shall have regard to the desirability of making  
4 food and medicine available to the public at the lowest  
5 possible cost consistent with giving the inventor a  
6 reward, and there are no other limitations other than that.

7 It was just an aside while Mr. MacLeod was  
8 looking something up.

9 THE CHAIRMAN: A patent is a licence to  
10 manufacture.

11 MR. HANSARD: That is what it would be.

12 THE CHAIRMAN: I don't see how a licence to  
13 import could come under that heading, but however, that  
14 is a matter of legal argument.

15 MR. MACLEOD: In the article in Fortune  
16 Magazine of August 1958, which is referred to in the  
17 Green Book, Schering's Structural Roulette, the following  
18 appears:

19 "The origin of the Metis goes back to 1949,  
20 when Merck & Co. Inc. announced a method for producing  
21 cortisone synthetically. Merck's process, however,  
22 conflicted with a number of patents, including some held  
23 by Schering for the production of sex hormones. To  
24 avoid litigation, a patent and royalty or cross-licencing  
25 agreement was made, through which Schering, among others,  
26 obtained cortisone-production information".

27 Do you know if any such situations such as  
28 that would be involved in the instances referred to in  
29 your survey?

30 MR. CONDER: I don't believe so.



1 MR. MACLEOD: The situation I am referring  
2 to is the one described here where one company needs the  
3 help of another company and you get a cross-licencing  
4 situation.

5 MR. CONDER: I had better say no, that I  
6 don't know for certain.

7 MR. MACLEOD: Are you aware that before  
8 the Ontario Select Committee Dr. Ferguson stated that he  
9 had been refused a licence for Connaught Laboratories to  
10 manufacture a drug which he considered important for the  
11 national welfare of Canada, and that he was refused; he  
12 stated he did not go to court because he was advised it  
13 was expensive and often ineffective.

14 MR. CONDER: I recall that, yes. I frankly  
15 do not necessarily blame the company involved in this  
16 although, frankly, I don't remember the name of the company  
17 concerned, because where a company does put a considerable  
18 amount of money into research and study and bringing about  
19 a product - as we mentioned here earlier we have one  
20 company that has put in something like 8 years in bringing  
21 a product to fruition - that company must necessarily have  
22 a personal and a very selfish interest in that product.

23 It does not want to throw everything that it  
24 has put into it financially and otherwise down the drain  
25 at that particular time. I don't know whether the product  
26 was at that time available in Canada by that company.  
27 Could you let me know about that?

28 MR. MACLEOD: As a matter of fact, I do know,  
29 but I am not giving evidence so we will have to let it go  
30 at that.



1 MR. FRAWLEY: The Connaught Laboratories  
2 did not apply for a compulsory licence.

3 MR. MACLEOD: That is my point. That was  
4 the point I was coming around to.

2 5 MR. CONDER: Did not the Commissioner of  
6 Patents, Mr. Michel, state in answer to something similar  
7 to that in his appearance before this Commission, that  
8 he thought that a good patent attorney and a good case,  
9 that an applicant for a licence could get it within a  
10 year?

11 MR. HUME: I think that too. I have for-  
12 gotten the evidence, but Mr. MacLeod knows. It is  
13 equally consistent that Dr. Ferguson came forward with  
14 such an outrageous proposition that the company turned it  
15 down, and he decided not to go to court. It is very  
16 difficult to arrive at any conclusions. He may have  
17 wanted it for nothing.

18 MR. MACLEOD: I understand what Mr. Conder  
19 said, and I appreciate the force of his argument, but  
20 the significant point seems to me that Dr. Ferguson was  
21 under the impression that it would be costly and perhaps  
22 not necessarily successful to go into the business of  
23 applying for a compulsory licence.

24 I put this to Mr. Michel, having reference  
25 to the evidence you are speaking of, and I asked him if  
26 that impression could not have been abroad until the  
27 decision in the Parke-Davis and Fine Chemicals case was  
28 taken to the Supreme Court of Canada and clarified the  
29 law in respect to compulsory licences. Mr. Michel said  
30 it is quite possible that that was so; that this case





1 which was either in 1959 or 1960 - in any event, quite  
2 recent - that until then the law had never been really  
3 clarified by the courts.

4 MR. HANSARD: What is the question to the  
5 witness?

6 MR. CONDER: Then it would appear, Mr.  
7 MacLeod, that possibly since it has been clarified by  
8 the courts, that any possible objection to it could be  
9 nullified.

10 MR. MACLEOD: Yes, possibly. My point is  
11 if Dr. Ferguson apparently held a bona fide impression  
12 on the availability of the compulsory licencing provisions,  
13 the impression must have been held by some segment of the  
14 trade at least.

15 MR. HUME: That is a conclusion of course.

16 MR. CONDER: Not being a member of the bar  
17 and not having a complete background in the field of  
18 patents, all I can say in answer to that is this: if the  
19 situation existed at one time, it apparently does not  
20 exist now because the Commissioner of Patents, Mr. Michel,  
21 has stated that a case can be brought to fruition within  
22 a year.

23 THE CHAIRMAN: I think you are getting down  
24 to a matter of argument.

25 MR. MACLEOD: Yes, but I am just suggesting  
26 the fact that Dr. Ferguson said this indicates that there  
27 is a belief, and this has no relation to the legal aspect  
28 at all - there was a belief at least up to the time before  
29 he appeared before the Select Committee of Ontario that  
30 compulsory licences were difficult to get, costly and



1 expensive.

2 MR. HANSARD: I don't think that follows.

3 THE CHAIRMAN: I don't think the witness  
4 can state that in fact or deny it either.

5 MR. MACLEOD: I am suggesting to the witness  
6 it does weaken his conclusion that is stated in the brief  
7 that compulsory licences are now practically a matter of  
8 right and anybody that wants one goes and gets one.

9 I understand you also suggest there may be  
10 a lot of private negotiations simply because the compul-  
11 sory licences ---

12 MR. HUME: I suggest what Mr. MacLeod  
13 thinks or what Dr. Ferguson believed does not in any way  
14 weaken the statement.

15 MR. MACLEOD: That is probably a matter of  
16 argument, Mr. Chairman. Now, in speaking of the results  
17 of your survey which you set out on page 75, I take it  
18 that the 39 companies are again the same companies which  
19 have been referred to earlier; is that so?

20 MR. CONDER: Yes. Just a minute, and I  
21 will get that for you. Survey No. 4.

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MR/nm

1 MR. MacLEOD: Those are all the questions  
2 I have sir.

3 THE CHAIRMAN: Are there any other questions  
4 anybody wishes to put to the witness? (No answer)

5 Thank you Mr. Conder.

6 MR. HUME: Mr. Chairman that is the only  
7 evidence that will of course be presented on behalf of  
8 the Association. I should like to make one further  
9 comment. On the first day of the sittings in Ottawa --  
10 the second day in dealing with the cross-examination of  
11 Mrs. Plumbtree, in dealing with her statement in her brief,  
12 in which she quoted the Director, and I have forgotten  
13 the page, I think it is 118 about promotional expenses in  
14 which the director had indicated that of the 23 firms that  
15 the Director had interviewed, there was a figure on page  
16 115 -- the Director indicated that of the twenty-some-odd  
17 firms -- 22 firms the amount spent on promotional expense  
18 was a figure there shown of 33.38%. This, Mrs. Plumbtree  
19 in her brief had parlayed into the entire industry.

20 I had made a statement in cross-examination  
21 that it all depended on which company you took because  
22 there had been a figure presented to the Ontario Committee  
23 that was considerably different. You quite properly  
24 interrupted me and said I should wait until we gave our  
25 own evidence to indicate this. With the hope of not  
26 starting anything, but not afraid of what might be  
27 started, I say that exhibit T-11 contains the result of  
28 a survey and that is where I got my figure.

29 I wanted to put on the record that the figure  
30 had some basis. I knew I had read it somewhere and on page



1 sixty something, I think it was -- here we are -- page 68  
2 of exhibit T-11 I merely point out there are 33 firms in  
3 Ontario being surveyed and that the amount, the percentage  
4 spent on journal advertising, direct mail, samples, and  
5 so on were shown at 6.5.

6 If the 33 companies accurately answered  
7 questions, they are obviously not the same companies the  
8 Director indicated and perhaps something between the two  
9 is the closer. I merely wanted to point out that figure  
10 was a matter of public record.

11 MR. WHITELEY: Perhaps you can prepare a  
12 comparable figure of your companies.

13 MR. HUME: This was a survey made.

14 MR. WHITELEY: I say perhaps you can compare.  
15 This figure here relates only to promotion.

16 MR. HUME: When you say "this figure here"--?

17 MR. WHITELEY: On page 66 of this exhibit  
18 T-11.

19 MR. HUME: Well it refers to journal  
20 advertising, direct mail, samples, medical exhibits and  
21 space and donations to meetings.

22 MR. WHITELEY: You have already mentioned  
23 a figure of 14% for detailmen so I presume this 6% added  
24 to the 14 should make 20?

25 MR. HUME: Yes. This has nothing to do  
26 with detailmen. This is purely a matter of the advertising,  
27 these notes I have read, it doesn't involve the expense  
28 of detailmen at all.

29 MR. WHITELEY: Let's take the point you are  
30 dealing with. You are dealing with paragraph 189 of the



1 Green Book?

2 MR. HUME: Yes.

3 MR. WHITELEY: It shows the expenditures of  
4 certain firms on advertising and promotion. I suggest  
5 that if you want to compare it with that figure that you  
6 prepare a figure on the same basis for the larger number  
7 of companies, and then we will have a true comparison.

8 MR. HUME: There is nothing in there as to  
9 what advertising and promotion contains, whether or not --  
10 the detailmen certainly would be employed but the question  
11 is whether or not they are charging up 100% of the detail-  
12 men. In this statement, or the percentage which is calculated  
13 in this brief that it may be not true. We are not  
14 comparing like and like and I am not casting any reflection  
15 on the figures on page 115. I merely wanted to complete  
16 the record by indicating that there was another figure and  
17 if you add the 6.5 with this most recent figure you still  
18 get considerably less than 33.38%.

19 MR. WHITELEY: It seems to me the only  
20 comparison you can make, if you are going to make one is  
21 take the larger number of companies and put their figures  
22 on the same basis as the 22. Then, whether it is an  
23 accurate figure or inaccurate ---

24 MR. HUME: I am not suggesting it is in-  
25 accurate.

26 MR. WHITELEY: I thought your contention  
27 was that you could not extend it to the larger number of  
28 companies.

29 MR. HUME: No. I am obviously not making  
30 myself clear. My purpose in bringing this up is firstly





1 that I am not questioning the accuracy, nor have we at any  
2 time questioned the accuracy of the figures on page 115  
3 of the Green Book but when we were discussing, when I was  
4 cross-examining Mrs. Plumbtree with respect to this, I  
5 indicated to her that other surveys -- she had made this  
6 as their own statement, that this was the Canadian average  
7 for the pharmaceutical industry and I merely was indicating  
8 to her that there were other figures and the Chairman said  
9 to me when you put your case in will you indicate what  
10 other figures and I am merely trying to. I had mentioned  
11 6.5 for journal advertising, direct mail, samples, medical  
12 expenses and I am merely now trying to draw attention to  
13 the page to justify -- I am not justified necessarily,  
14 but I wanted to indicate I was not taking this figure  
15 off the top of my head. It had been recorded.

16 MR. WHITELEY: I don't think we can pursue  
17 that line of enquiry at all. We don't know on what basis  
18 the other company figures have been compiled. Unless they  
19 are compiled on the same basis as the Green Book then they  
20 are not comparable.

21 MR. HUME: If we can get that, we can find  
22 out whether they are comparable. You say they are not  
23 and I don't know whether they are or not. I don't know  
24 what information you have that they are not.

25 MR. WHITELEY: That is what I suggest is  
26 the course to pursue, that you take your 33 or 35 or 39  
27 companies, take their figures and prepare them on the  
28 same basis and then we can compare.

29 MR. HUME: I don't want to compare them.  
30 I am merely trying to indicate, as I have said twice now



1 where I got that figure. I am merely giving the page  
2 number so the record indicates that this was a responsible  
3 statement of mine. If you want to leave it at that, that  
4 is fine.

5 THE CHAIRMAN: That seems to conclude all  
6 that we will be hearing from the Manufacturers Association.  
7 It is half past three. We usually go a bit later than  
8 this. Is there anybody here who has a short presentation  
9 that might be given fairly quickly, because we have a  
10 little time? Might as well dispose of a short presenta-  
11 tion if there is such a thing.

12 MR. HANSARD: That's a dangerous assumption.

13 THE CHAIRMAN: Nobody wishes to think it  
14 might be short. Mr. McNabb is not here is he this  
15 afternoon? (No answer)

16 There is one small thing we might get in  
17 since we have a little time. There is a statement to us  
18 as a brief from a drug store, a druggist in Wallaceburg,  
19 Ontario and the man who wrote it, who is the proprietor  
20 of the drug store, said he hoped he would be here. He  
21 would do his best to be here. If he wasn't he would like  
22 to have it dealt with in full, so perhaps we might read  
23 it so if anybody here wishes to question or make comments  
24 on it then they will have the information. I am assuming  
25 Mr. Brander is not here, is that right? I have not heard  
26 from him at any time during the week. (No answer).  
27 Perhaps we might read this. It is only two or three pages,  
28 will only take a very few minutes. I suspect there won't  
29 be too many questions, though I can be wrong about that.  
30 This is addressed to the Commission, to me as Chairman of



1 the Commission from Mr. A. P. Brander, Rexall Drug Store,  
2 Wallaceburg, Ontario.

3 Brief to Mr. C. Rhodes Smith,  
4 Chairman Restrictive Trade Commission,  
5 OTTAWA, Ontario.

6 Sir:

7 Just a few items I would like to point out  
8 and enter into the files of your inquiry.

9 RESEARCH.

10 The health of the nation has improved so  
11 greatly due to research progress in new drugs that life  
12 expectancy has increased ten years in the last thirty years.

13 Hospital days stay have been reduced from  
14 13.9 days to 8 days since 1958.

15 Research has produced the so called wonder  
16 drugs at a great cost to the pharmaceutical industry.

17 Eli Lilly spent 8.6% of each sales dollar before taxes  
18 in research.

19 Scherling Co. spent 8.5% of each sales dollar before taxes.

20 Upjohn spent 8.9% in research before taxes.

21 S.K.F. Co. 8.7% before taxes of each sales dollar.

22 Of every ten products developed and tested  
23 only one reached the market to produce an average return  
24 to the manufacturer of 10 to 11%, 4.3% to the pharmacist.

25 In the field of enzyme research alone many  
26 millions have been spent and will be spent. The field of  
27 enzymology represents new horizons in health fields in the  
28 world. If the work is not discouraged by Commission  
29 Reports.

30 RELATIVE COST.

In 1958 people spent \$55.00 for alcohol



\$34.00 for tobacco  
and only \$12.00 for prescription drugs  
on the average for the continent.

The average family needs only \$750.00 worth  
of drugs for a lifetime or the equivalent of 1/3 the cost  
of a small automobile.

#### PROFITS.

The Government owned Polymer Corporation Ltd.  
in Sarnia reported a net profit last year of \$9,850,479  
on gross sales of \$85,914,811.

Mr. Ralph Rowzee, President said this.  
"When you operate a corporation under sound business  
principles in the best tradition of the free enterprise  
system, you expect to make money. We've paid our way and  
we haven't had any interference from Ottawa."

The net for Polymer compares very closely  
with the net from most of the pharmaceutical companies for  
1960.

A close working company to the Government  
owned Polymer, the Imperial Oil Company, developed the  
Leduc Oil Fields in Alberta after millions of dollars had  
been spent in research and drilling dry holes. Had they  
been stopped from this research we would still be dependent  
on the U.S. for our bulk petroleum products. Research in  
finding oil, research in the new uses of petroleum products  
have greatly added to Imperial's financial status of today.

The retail pharmacist spends an average of  
5½ years completing his pharmacy education. He is a  
professional man or woman trained in the use of and handling  
of all drugs used in today's medical field. His is the  
responsibility and his alone for the proper filling of



1 prescriptions and for the quality of drugs that enter into  
2 these prescriptions. The will of the Doctor and the  
3 health of the patient are and must ever be his chief concern.

4                   Probably no other profession in Canada  
5 takes less in profit for its labour than retail pharmacy  
6 does today. Long hours, terrific strain and constant vigil  
7 produce the high quality service the public expect from  
8 their family pharmacist.

9                   The cost of living index as applied to  
10 Drugs has risen less during the past TEN years than any  
11 other field of household expenses. The cost of many drugs  
12 has dropped considerably in the past ten years as research  
13 costs have been returned and written off. Penicillin,  
14 alone has been reduced until to-day a one million unit  
15 tablet costs only FORTY CENTS to the patient, while ten  
16 years ago the same amount of units would have cost ten  
17 dollars.

18                   To consider the pound cost of an automobile,  
19 a gallon of oil at the well, a cord of wood in the bush,  
20 a ton of iron at the mill would be just as sensible as  
21 saying that a tablet that cost five cents in bulk is out-  
22 rageous when it costs 25¢ to the customer. These costs  
23 are relative.

24                   Pharmacy retail, wholesale or at the  
25 manufacturing level has never been afraid of the light  
26 of publicity. It has a long record of the finest in  
27 public service. It is proud of what little part it has  
28 played in the life of the nations. The little it has been  
29 able to do for Dr. Switzer, Dr. Doolittle, Hospital Ship,  
30 Hope and many many places where it has served unsung.





1 pharmacy only asks that the case be  
2 presented fairly and that figures which are so easily  
3 misunderstood are not so used that they confuse the issue  
4 and present an untrue picture.

5 A. P. Brander.

6 There is the brief which we were asked to  
7 present in full. A great deal of it, like some other  
8 material we have had is fairly general without giving us  
9 the background but we have his position and opinion stated  
10 fairly strongly.

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1 THE CHAIRMAN: Are there any points that  
2 anybody here thinks should be brought up in relation to  
3 this presentation?

4 MR. HANSARD: I would like to say, we may  
5 have laughed a little too much at some of the points.  
6 It seems like a pretty well-composed document, Mr. Chair-  
7 man.

8 THE CHAIRMAN: It is prepared with care.

9 MR. HANSARD: I don't know what the sources  
10 of his figures are. His arguments are pretty sound.

11 THE CHAIRMAN: What I was saying something  
12 about in the first place, it is like some other instances  
13 before the Commission, we have heard a good many state-  
14 ments of fact about which we have no means of verifi-  
15 cation.

16 MR. HANSARD: Quite.

17

18 --- OFF RECORD DISCUSSION

19

20 THE CHAIRMAN: If there are no others  
21 ready to make presentations we will adjourn to Monday  
22 morning at 10 o'clock with the intention of taking up at  
23 that time the presentation of the Pharmaceutical Associa-  
24 tion. There are one or two others, as you know, and if  
25 people who are making presentations wish to arrange some  
26 other order among themselves I don't think there will be  
27 any objection.

28

29 --- Whereupon the hearing adjourned until 10 a.m.,

30

Monday, October 23rd, 1961.



INQUIRY UNDER SECTION 42  
OF THE COMBINES INVESTIGATION ACT

Relating to the manufacture, distribution and sale  
of drugs

By Director of Investigation and Research  
Combines Investigation Act

COMMISSION:

C. RHODES SMITH, Q.C.	-- Chairman
A.S. WHITELEY, M.A.	Member of the Commission
PIERRE CARIGNAN, Q.C.	Member of the Commission
F. N. MacLEOD	Combines Officer, representing the Director of Investigation and research

Proceedings of hearings commencing at  
10.00 a.m., Monday, October 23rd, 1961,  
et seq in the City of Toronto, in the  
Province of Ontario.





1 ---Upon resuming at 10.00 a.m.

2

3 THE CHAIRMAN: Gentlemen, I believe there  
4 is a suggestion for a change in the order of presentations  
5 of the briefs this morning. Mr. Cook, have you something  
6 to say on that?

7 MR. COOK: No, I don't want to interrupt  
8 you, sir.

9 THE CHAIRMAN: I understand the Canadian  
10 Society of Hospital Pharmacists were anxious to get on this  
11 morning because Mr. Summers who will be presenting the  
12 brief must be back in the West within a day or so. It may  
13 be that the Pharmaceutical Association's brief will take  
14 quite a while. I understand that the Pharmaceutical  
15 Association does not object to Mr. Summers proceeding this  
16 morning.

17 MR. COOK: That is correct.

18 THE CHAIRMAN: In that case we will call  
19 Mr. Summers.

20 PROF. SUMMERS: Mr. Chairman, Members of  
21 the Commission, I am J. L. Summers of Saskatoon,  
22 Saskatchewan, Associate Professor of Pharmacy at the  
23 University of Saskatchewan. I am also a practising  
24 hospital pharmacist and also I am the Director of the  
25 Pharmaceutical Services of the University Hospital in  
26 Saskatoon. Sir, I request your direction. We have  
27 attempted to document our statements as fully as possible.  
28 Do you wish such documents and references read aloud or  
29 may we take them as read, sir?

30 THE CHAIRMAN: I think, as long as they are





1 clearly in the brief we will have them and that is the  
2 important thing.

3 SUBMISSION OF

4 THE CANADIAN SOCIETY OF HOSPITAL PHARMACISTS

5 INTRODUCTION:

6 The Canadian Society of Hospital Pharmacists  
7 is the professional association of pharmacists in Canada  
8 engaged in the practice of pharmacy in hospitals. The  
9 Society was founded in the year 1947. In 1948, By-Laws  
10 were formulated and submitted to the Secretary of State  
11 of the Canadian Government. A Dominion Charter, under  
12 Part II of the Companies Act, 1934, was granted to the  
13 Society in 1950. The Minimum Standard for Pharmacies in  
14 Hospitals was adopted at the Annual Meeting in Ottawa in  
15 1956. (Frances, Sister M.: History of the Canadian Society  
16 of Hospital Pharmacists, Hospital Pharmacist, 10:269,  
17 Sept.-Oct., 1957; 11: 40, Jan.-Feb., 1958; 11: 76, Mar.-  
18 April, 1958) In 1961, at the Annual Meeting of the Society  
19 in Hamilton, a new set of By-Laws was adopted and a  
20 recommended set of Minimum Standards was approved. Sir,  
21 may I submit our by-laws and our minimum standards as  
22 exhibits?

23 THE CHAIRMAN: Yes, it will be exhibit T-12.  
24 Is it the original by-laws and the amended ones?

25 PROF. SUMMERS: These are the present ones,  
26 the new ones have been approved and approved in principle  
27 by the Secretary of State.

28 THE CHAIRMAN: And this is the minimum  
29 standards. This will be exhibit T-13.

30



1 ---EXHIBIT T-12:

By-laws.

3 ---EXHIBIT T-13:

Minimum standards.

5 This Brief is specifically presented as the  
6 result of a resolution moved, seconded, and adopted at  
7 the Annual Meeting of the Canadian Society of Hospital  
8 Pharmacists held in Hamilton, August, 1961, which reads,  
9 "whereas the scope of the investigations of the Restrictive  
10 Trade Practices Commission has touched on such matters as  
11 pharmaceutical education, generic terminology and the use  
12 of the Formulary system, and whereas these are matters of  
13 extreme concern to the members of the Society, be it  
14 resolved that the Canadian Society of Hospital Pharmacists  
15 request permission of the Commission to present a brief  
16 concerning these matters".

17 The Canadian Society of Hospital Pharmacists,  
18 an affiliate member of the Canadian Pharmaceutical Association,  
19 in presenting this Brief, approves the statement of the  
20 Canadian Pharmaceutical Association issued on May 5, 1961,  
21 that we "welcome a sane comprehensive investigation related  
22 to the manufacture, distribution, and sale of drugs in  
23 Canada. The Association is of the opinion that such a  
24 review will provide the public with proper facts and in  
25 doing so, will dispel the element of distrust which, if  
26 allowed to continue, will seriously affect the proper  
27 utilization of drug therapeutic agents with consequent  
28 adverse results on general health and welfare". (A Statement  
29 by The Canadian Pharmaceutical Association: Combines  
30 Investigation inquiry, May 5, 1961, mailed to members.)



1                   The Society is aware that in the preface of  
2 "Material Collected for Submission to the Restrictive  
3 Trade Practices Commission.....relating to the Manufacture,  
4 Distribution and Sale of Drugs.....", as prepared by the  
5 "Director of Investigation and Research of the Combines  
6 Investigation Act", Director D.H.W. Henry states, "The  
7 inquiry has not been concerned with the level of prices, as  
8 such, or whether prices are reasonable. Rather, as the  
9 statute contemplates, the inquiry has been concerned with  
10 the question whether the prices of drugs in Canada are the  
11 result of conditions or practices related to monopolistic  
12 situations or restraint of trade".

13                   As our statement concerns neither prices  
14 nor restrictive trade practices directly it may be  
15 suggested that it is not relevant to the hearings of this  
16 Commission. However, the subjects of pharmaceutical  
17 education, generic terminology and the Formulary system  
18 have been repeatedly mentioned in the discussions and the  
19 Canadian Society of Hospital Pharmacists would like to  
20 take this opportunity to present some facts relative to  
21 these subjects which are of concern to pharmacists engaged  
22 in the practice of pharmacy in hospitals.

23                   The subject matter in this Brief, relative  
24 to hospital pharmacy, will be confined to the following:

- 25                   1. Education
- 26                   2. The Formulary System
- 27                   3. Drug Nomenclature
- 28                   4. The Assessment of Quality

29                   1. EDUCATION

30                   During the course of the investigation it



1 has been suggested that the pharmacist does not require  
2 the amount of education which he usually receives today.  
3 (Mr. McLeod - Vol. 8, page 829, line 21-29.) With regard  
4 to education, hospital pharmacists as members of the  
5 Canadian Society of Hospital Pharmacists submit that the  
6 present four year course leading to the B.Sc. degree in  
7 Pharmacy must be considered as a minimum requirement and  
8 is insufficient in many cases for those engaged in the  
9 management functions of a hospital pharmacy. In this  
10 opinion the Canadian Society of Hospital Pharmacists is  
11 supported by a prominent hospital administrator, Dr. A.L.  
12 Swanson, a recognized Canadian authority on hospital  
13 administration, and Dr. B. E. Riedel, Professor of Pharmacy  
14 at the University of Alberta, speaking for the members of  
15 the Canadian Conference of Pharmaceutical Faculties.  
16 Swanson, A.L.: What the administrator expects from the  
17 pharmacist, Hospital Pharmacist, 12: 15, Jan.-Feb., 1959;  
18 Riedel, B.E., Chairman Teachers' Conference on Hospital  
19 Pharmacy: Introduction, Bulletin Canadian Conference of  
20 Pharmaceutical Faculties, 13: 138, Aug.-Sept., 1960)

21                   The Canadian Society of Hospital Pharmacists  
22 as a professional organization founded to "improve and  
23 extend the usefulness of hospital pharmacists to the  
24 institution which they serve" as stated under the objectives  
25 in the By-Laws of the Society, has approved a new Minimum  
26 Standard for Pharmacies in Hospitals. (Exhibit) Hospital  
27 pharmacists must utilize all their professional knowledge  
28 and ability and administrative skills in order to meet all  
29 the elements of these standards. Furthermore, hospital  
30 pharmacists must fulfill the expectations of the



1 administrator of the hospital to whom they are responsible.  
2 These have been outlined by Dr. A.L. Swanson, Executive  
3 Director, University Hospital, University of Saskatchewan,  
4 Saskatoon, as follows: (1) advice to management on pro-  
5 fessional matters, (2) organization and management of the  
6 pharmacy department, (3) professionalism, (4) budgeting,  
7 (5) accounting, (6) purchasing, using sound purchasing  
8 procedures, (7) administration of the control and safe use  
9 of drugs in the hospital, (8) effective communication,  
10 (9) training of personnel, and (10) continuing self  
11 education and improvement. (Swanson, A.L.: What the  
12 administrator expects from the pharmacist, Hospital  
13 Pharmacist, 12: 15, Jan.-Feb., 1959.)

14               The hospital pharmacist has found it  
15 necessary to develop a program of continuing education  
16 to keep up to date with therapeutic trends and the growth  
17 and development of hospitals. To meet this need, the  
18 Canadian Society of Hospital Pharmacists holds meetings  
19 at the Branch and Chapter level, sponsors Institutes, and  
20 publishes the Hospital Pharmacist, which is the official  
21 journal of the Society. If possible I would like to submit  
22 three years' copies of the journal as an exhibit in order  
23 that the type of educational program which we are presenting  
24 in our publications may be available to you.

25               THE CHAIRMAN: We will put these all together  
26 as exhibit T-14.

27  
28 ---EXHIBIT T-14:

Three years copies of The  
Hospital Pharmacist.

29  
30 In fact, Hospital Pharmacy as a specialized





1 field of pharmacy has so developed in recent years that  
2 Dr. B. E. Riedel, Chairman of the Teachers' Conference  
3 on Hospital Pharmacy, at the meeting of the Canadian  
4 Conference of Pharmaceutical Faculties held in Saskatoon,  
5 August 1960, stated, "It is generally recognized that  
6 some program of specialization beyond the basic degree of  
7 pharmacy training is required to adequately fit a pharma-  
8 cist for his responsibilities in a hospital. Differences  
9 in the sizes of hospitals, and therefore in the require-  
10 ments for a pharmacist, make this problem one of varying  
11 proportions." (Riedel, B.E., Chairman Teachers' Conference  
12 on Hospital Pharmacy: Introduction, Bulletin Canadian  
13 Conference of Pharmaceutical Faculties, 13: 138, Aug-Sept.,  
14 1960).

15 The discussions at the Teachers' Conference  
16 of the Canadian Conference of Pharmaceutical Faculties in  
17 August 1960 resulted in the following resolution which was  
18 moved, seconded and adopted.

19 "In view of the reported developments in  
20 hospital pharmacy the Teachers' Conference recommends to the  
21 Canadian Conference of Pharmaceutical Faculties that its  
22 appropriate committees take under consideration the  
23 following matters:

- 24 (a) Undergraduate curriculum
- 25 (b) Graduate curriculum
- 26 (c) Certification
- 27 (d) Approval of hospitals
- 28 (e) Participation of universities in hospital  
29 internship programmes."

30 (Murray, J.R.: Summary of the Teachers' Conference on



1 Hospital Pharmacy, Bulletin Canadian Conferences of  
2 Pharmaceutical Faculties, 13: 194, Aug.-Sept., 1960).

3 The Canadian Society of Hospital Pharmacists  
4 adopted a Minimum Standard for Pharmacy Internship in  
5 Hospitals, and approved the establishment of a Board of  
6 Approval of Hospitals for Hospital Pharmacy Internships  
7 in conjunction with the Canadian Conference of Pharma-  
8 ceutical Faculties at the annual meeting of the Society  
9 in August, 1961. (Canadian Society of Hospital Pharmacists,  
10 Education Committee Report: Standard for the approval of  
11 hospitals for hospital pharmacy internships in Canada.  
12 Mimeographed report adopted at the Annual Meeting in  
13 Hamilton, Ontario, August, 1961) "On the basis of the  
14 facts and opinions which have been presented, the CSHP  
15 submits that present standards of pharmaceutical education  
16 are necessary, and indeed are barely adequate, to prepare  
17 the pharmacist for hospital practice".

18 2. THE FORMULARY SYSTEM

19 In this and other investigations, frequent  
20 mention has been made of the Formulary System, which is an  
21 accepted part of modern hospital practice. It is evident  
22 from these discussions that the principles and the opera-  
23 tion of the Hospital Formulary System are often mis-  
24 understood.

25 Under the Formulary System, a medical staff  
26 member agrees that when he prescribes by proprietary name  
27 the pharmacist is authorized to dispense the prescribed  
28 drug under its non-proprietary name, irrespective of  
29 whether it is or is not of the same brand referred to in  
30 the prescription or order. In effect the medical staff



1 of the hospital authorizes the hospital pharmacist to  
2 exercise his professional judgment in the selection of the  
3 suppliers of the drugs dispensed.

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/JW/dsw

1 THE CHAIRMAN: Mr. Summers, you have used the  
2 term "proprietary name". Is that the same as "trade name"?

3 PROF. SUMMERS: Yes sir.

4 In order to better understand the principles  
5 involved, definition of terms indicates that:

6 1. The Hospital Formulary System is the  
7 method by which the medical staff, through  
8 the Pharmacy and Therapeutics Committee,  
9 studies and selects drugs which they consi-  
10 der are the most useful for the treatment  
11 of the patients.

12 2. The Pharmacy and Therapeutics Committee  
13 is a committee of the medical staff which  
14 represents the official line of communication  
15 and liaison between the medical staff and  
16 the pharmacy department. It is generally  
17 composed of the hospital pharmacist and  
18 physicians appointed by the medical staff.  
19 The discussions and recommendations of this  
20 Committee are approved by the medical staff  
21 and the administrative authorities of the  
22 hospital before they are implemented in the  
23 hospital.

24 "A valid hospital formulary program is  
25 based upon its approval by the organized medical staff,  
26 the consent of individual staff members, the functioning  
27 of a properly motivated Pharmacy and Therapeutics Committee  
28 of the medical staff, and upon acceptance of the use of  
29 nonproprietary terminology". (Statement of guiding prin-  
30 ciples on the operation of the hospital formulary system.



1 Approved by the Board of Trustees of American Hospital  
2 Association, August 27, 1960, and by the Executive Commit-  
3 tee of American Society of Hospital Pharmacists August 16,  
4 1960, Hospitals, 34: 54, October 16, 1960).

5 A Hospital Formulary or Drug List is a compi-  
6 lation of pharmaceuticals which reflect the clinical judg-  
7 ment of the medical staff. The use of a hospital formulary  
8 in a hospital is recommended by the Canadian Council on  
9 Hospital Accreditation. Dr. W.I. Taylor, Executive Director  
10 of the Canadian Council on Hospital Accreditation supports  
11 this view. In an address presented to the first One Day  
12 Institute in Hospital Pharmacy, jointly sponsored by the  
13 Ontario Branch of the Canadian Society of Hospital Pharma-  
14 cists and the Ontario College of Pharmacy, Toronto, May 2,  
15 1959, Dr. Taylor stated, "---while the six essentials for  
16 a pharmacy as stated in the Standards, (Standards for  
17 Accreditation of Canadian Hospitals) do not mention either  
18 a pharmacy and therapeutics committee or a formulary or  
19 drug list, both are considered desirable because of their  
20 potential contribution to better patient care in hospitals,  
21 and hospitals of all sizes and types can put the principles  
22 into effect modifying the function to suit the institution".  
23 (Taylor, W.I.: Pharmacy and therapeutics committee and the  
24 formulary system, Hospital Pharmacist, 12: 115, May-June,  
25 1959).

26 In establishing a Formulary system in a  
27 hospital, it is essential that the consent of each person  
28 authorized to write a prescription be obtained. This may  
29 be done by:

30 1. Incorporating the basic policies in the





1 medical staff by-laws, or rules and regula-  
2 tions.

3 2. Obtaining separate documents from each  
4 physician, or

5 3. Having a statement printed on each  
6 prescription form.

7 Certain principles necessary to the func-  
8 tioning of the system include written policies and proce-  
9 dures, and provisions for the use of drugs not included in  
10 the formulary, and provisions for the control and use of  
11 investigational drugs. The pharmacist, under the guidance  
12 of the Pharmacy and Therapeutics Committee is responsible  
13 for specifications as to the quantity, the quality and the  
14 source of supply of all drugs, chemicals, biologicals and  
15 pharmaceutical preparations.

16 The operation of the Formulary System,  
17 while it may restrict the physician to choice of brand,  
18 does not curtail his choice of drug. Although better  
19 controlled inventories result through the use of the Formu-  
20 lary System, its primary purpose is the promotion of  
21 better patient care, through rational drug therapy by the  
22 regular review and evaluation of drugs and all policies  
23 pertaining to their administration.

24 3. DRUG NOMENCLATURE

25 Discussions of drug nomenclature and termi-  
26 nology have been frequently documented in the official  
27 transcripts of this investigation. Such terms as generic  
28 names, proprietary names, non-proprietary names, official  
29 names, brand names, etc., have been repeatedly referred to  
30 and defined. It should now be obvious to the Commission



1 that the whole field of drug nomenclature is lacking in  
2 clarity and precision. Both proprietary and non-proprie-  
3 tary nomenclature is now largely devoid of any precise  
4 meaning.

5                   As hospital pharmacists we feel that the  
6 most enlightening and useful interpretation has been  
7 expressed by Dr. Lloyd C. Miller in an article entitled,  
8 "Doctors, Drugs, and Names" published in the Journal of the  
9 American Medical Association, July 8, 1961. On the subject  
10 of generic or nonproprietary names, Dr. Miller quotes  
11 Stecher, P.G.: Generic names of drugs, J. Chem. Educ., 34:  
12 454-456 (Sept.) 1957, as follows:

13                   "The adjective generic obviously comes from  
14 the Latin word genus and suggests classifica-  
15 tion into genera as is the practice in botany  
16 and zoology. Actually the term is a misnomer  
17 as used in the drug field. The generic name  
18 does not relate to a class or genus of drugs;  
19 it denotes a single drug. Generic here is  
20 taken as opposed to specific. Specific  
21 applies to the trademark (also called brand  
22 or proprietary name) which is specific to one  
23 sole owner, while the generic name is nonpro-  
24 prietary. The term non-proprietary is more  
25 accurate and descriptive, but generic sounds  
26 better, is shorter and easier to pronounce -  
27 and so will probably stay with us for a long  
28 time to come, although it is a contradictory  
29 term. It most decidedly does not describe a  
30 genus or kind of product common to all the



1 pharmaceutical trade. It does denote or  
2 should denote a unique substance definable  
3 in chemical nomenclature as a single chemi-  
4 cal compound, not to be confused with any  
5 other substance of the same kind of belonging  
6 in the same group of drugs. This definition  
7 has been broadened to allow the coining of  
8 generic names for natural aggregates of sub-  
9 stances such as extracts of plant or animal  
10 origin, but excludes proprietary mixtures  
11 where each component has its own generic  
12 name". (Quoted by Miller, L.C.: Doctors,  
13 drugs, and names, J.A.M.A., 177: 27, July 8,  
14 1961 from Stecher, P.G.: Generic names of  
15 drugs, J. Chem. Educ., 34: 454-456 (Sept.  
16 1957).

17 The Canadian Society of Hospital Pharmacists

18 believes:

- 19 1. that some rational system of nomencla-  
20 ture is essential;
- 21 2. that the present system of naming drugs  
22 has failed, and
- 23 3. to be meaningful any system should be  
24 "generic" in that it should denote the  
25 chemical class to which the drug belongs.

#### 26 4. THE ASSESSMENT OF QUALITY

27 As previously stated in our discussion of the  
28 Formulary System, the hospital pharmacist is responsible  
29 for the quality of drugs and preparations used in the  
30 hospital. Much has been said about quality of drugs during



1 these hearings and many recommendations and suggestions  
2 have been made on the subject. It is the considered  
3 opinion of the Society that the most rational approach to  
4 the problem of drug assessment is that expressed by Dr.  
5 C.A. Morrell on page 13 of the Green Book, where he says:

6 "When it comes to buying top-quality drugs,  
7 the things to check are the ability, facili-  
8 ties, personnel and conscience of the drug  
9 manufacturer, Dr. C.A. Morrell, Canada's  
10 Chief Drug Inspector, said today.

11 Neither a brand name nor a drug's generic  
12 name is the sole reliable guide to quality,  
13 he said.

14 The real point is who makes the drug and how  
15 it's made - the control system that insures  
16 careful and scientific testing for potency  
17 and stability".

18 Quoted from (Toronto Globe & Mail, Aug. 18,  
19 1960).

20 At the Hospital Pharmacy Institute in Saska-  
21 toon, August, 1960, Dr. Morrell stated, "It is the function  
22 of the employees of the Food and Drug Directorate to induce  
23 the manufacturer and others to accept their responsibilities.  
24 The Food and Drug Act does not guarantee that all drugs  
25 will meet the standards of quality expected of them. All  
26 we can do is correct violations wherever we find them, and  
27 in certain cases, punish those who do not accept their  
28 responsibility. I think this is the proper function of our  
29 Directorate. We should not act as a control laboratory  
30 for the manufacturing pharmacist". (Morrell, A.C.: Role of



1 the Food and Drug Directorate in maintaining quality,  
2 Hospital Pharmacist, 14: 53, Mar.-April, 1961).

3 It is suggested that if a greatly expanded  
4 program of analytical control were undertaken by the Food  
5 and Drug Directorate, responsibilities which should be  
6 accepted by the drug manufacturers might be transferred to  
7 the Directorate with the inherent danger that it would  
8 become an analytical control laboratory for the entire  
9 pharmaceutical industry. We respectfully suggest that  
10 both in-plant and analytical controls are normal functions  
11 of every manufacturer and not the responsibilities of a  
12 government agency.

13 Our associations, as hospital pharmacists,  
14 with pharmaceutical manufacturers who have accepted their  
15 responsibilities have been most co-operative and helpful.

16 In conclusion, the Canadian Society of  
17 Hospital Pharmacists respectfully submits the following  
18 recommendations for consideration by the Commission:

19 (a) That an Advisory Committee on Drug  
20 Nomenclature be established for the purpose  
21 of devising non-proprietary names and of  
22 assigning them to new drugs. Such a Commit-  
23 tee should represent the pharmaceutical  
24 industry, the medical profession, the practi-  
25 sing pharmacist and the Food and Drug Direc-  
26 torate. It should function with such expe-  
27 diency as to ensure no unnecessary delay in  
28 the release of new drugs.

29 The names devised by this Committee should  
30 be simple, easily remembered, pronounceable,





1 acceptable to the physician who is not a  
2 chemist, and should enable the chemical  
3 classification of new compounds to be recog-  
4 nized.

5 (b) That appropriate legislation be enacted  
6 to specify the general nature of in-plant and  
7 analytical control procedures required of  
8 pharmaceutical manufacturers.

9 To make such legislation effective, the staff  
10 of the Food and Drug Directorate should be increased to  
11 enable it to carry out frequent plant inspections and thus  
12 ensure that the required controls are being carried out in  
13 the true spirit of the legislation.

14 Mr. Chairman and members of the Commission,  
15 on behalf of the members of the Canadian Society of Hospi-  
16 tal Pharmacists, may I thank you for this opportunity to  
17 present our views on this limited range of subjects  
18 directly affecting the practice of pharmacy in hospitals.

19 These facts, opinions and recommendations  
20 contained in this statement are presented in a sincere  
21 effort to be of assistance to you, sir.

22 THE CHAIRMAN: Mr. Summers, do you wish to  
23 add anything yourself to the statements in the brief?  
24 Have you any further comments you would like to make?

25 PROF. SUMMERS: I have no further comments.  
26 I would be pleased to answer any questions you may want to  
27 ask me.

28 THE CHAIRMAN: I have one question that  
29 occurs to me in connection with the formulary system.  
30 As I understand it, your Committee deals with drugs and



1 the hospital's resident pharmacist, if it has a resident  
2 pharmacist, assumes the responsibility with the approval  
3 of the practising physicians, of determining that, one,  
4 two, three, four or six drugs which may have separate  
5 proprietary or trade names, may be used interchangeably  
6 for the same purpose, is that it?

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C/EMT/hm 1

PROF. SUMMERS: That is right, sir, yes.

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THE CHAIRMAN: We have had some representa-

3

tions that although a drug, the basic drug in a prepara-

4

tion may be the same, if when it is made by several

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different companies and sold under trade names there are

6

differences in the dosage itself, in the way it acts and

7

reacts on the patient. Have you any problems of that

8

kind?

9

PROF. SUMMERS: No, sir. I feel these are

10

things where the hospital pharmacist is expected to

11

exercise professional judgment. If he can't do this, he

12

should not be a professional pharmacist.

13

THE CHAIRMAN: A doctor may prescribe a

14

drug made by Ayerst, and another one may prescribe one by

15

Cyanamid or Upjohn because he thinks it will act a little

16

bit differently.

17

PROF. SUMMERS: In the formulary system

18

there is provision for this thing, for this type of

19

problem. If the physician believes that such a drug in

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fact is more clinically effective and can present con-

21

clusive evidence to the Pharmacy-Therapeutics Committee

22

that it in fact does do so, then he may request that this

23

drug be brought in.

24

THE CHAIRMAN: It is not simply at his

25

request; it is on production of proof to satisfy the

26

Committee that for the particular purpose he has in mind

27

one particular brand name drug is more suitable to get

28

the desired result?

29

PROF. SUMMERS: This is normally taken care

30

of in the procedure by which the physician grants his



1 permission for the implementation of the formulary system.  
2 In other words, he subscribes to the by-laws of the medical  
3 staff which in fact states that where more than one  
4 trade name exists for the same basic drug or its prepara-  
5 tion, the basic drug and/or its preparation will be supplied,  
6 but not necessarily in the trade name mentioned in the  
7 prescription. In doing this he accepts the principle that  
8 the pharmacist has used his judgment and selected these  
9 drugs which will do the task for him. He has already  
10 given me authority to exercise my judgment.

11                   However, if he did come down and insist,  
12 I am sure it would be provided for him.

13                   THE CHAIRMAN: Are doctors practising in  
14 the hospital that have adopted the formulary system  
15 entitled to refuse to accept the formulary system?

16                   PROF. SUMMERS: They are, but in that case  
17 the Hospital Board would refuse the right to have them on  
18 the staff of the hospital.

19                   THE CHAIRMAN: They are not on the staff  
20 of the hospital then?

21                   PROF. SUMMERS: That is right, sir, yes.  
22 I think we must realize, sir, in the hospital community  
23 this is a very carefully controlled community. It is a  
24 very close community, and in all of my years in hospital  
25 pharmacy we have never had such an instance as this occur  
26 where our judgment has been questioned.

27                   THE CHAIRMAN: What we are getting at of  
28 course is how it works because we have had a good deal of  
29 evidence to the effect that a doctor must be in a position  
30 to select the particular drug, that is, the specific trade



1 name drug that he desires which he feels is better for  
2 a particular patient. In private practice that seems to  
3 be put forward. You haven't had too much trouble with that  
4 in hospitals?

5 PROF. SUMMERS: No, we haven't, sir. We  
6 have had no problem.

7 THE CHAIRMAN: Do you use to any great  
8 extent drugs which have no trade name, that are simply  
9 sold under the generic name?

10 PROF. SUMMERS: Of course this is -- all  
11 drugs may be sold under their non-proprietary name.

12 THE CHAIRMAN: Yes.

13 PROF. SUMMERS: In fact this is the way in  
14 which we order many of our drugs. There are some of  
15 course which are mixtures of drugs which have no non-  
16 proprietary or official name, and therefore this must be  
17 ordered by the trade name.

18 THE CHAIRMAN: There are a number made by  
19 only one manufacturer under one name. You can't get the  
20 same thing from any other source?

21 PROF. SUMMERS: That is right.

22 THE CHAIRMAN: But as I understand it, you  
23 do order a great many of your drugs simply by non-  
24 proprietary or generic name?

25 PROF. SUMMERS: Oh, yes, sir. Many drugs  
26 are only available by the non-proprietary name. All of  
27 the major manufacturers sell a portion of their drugs  
28 under non-proprietary names.

29 THE CHAIRMAN: Take, for example, the  
30 tetracyclines.





1 PROF. SUMMERS: Yes, sir.

2 THE CHAIRMAN: Under a number of trade  
3 names.

4 PROF. SUMMERS: Yes, sir.

5 THE CHAIRMAN: I suppose also it can be  
6 produced without a trade name. Is there any company which  
7 produces it without a trade name?

8 PROF. SUMMERS: Some companies do market  
9 it under its official only, yes.

10 THE CHAIRMAN: And if one of your hospitals  
11 was ordering tetracycline where it is ordered under the  
12 non-proprietary name, you would call for tenders?

13 PROF. SUMMERS: I can tell you only my  
14 own personal procedure. We submit tenders for tetracycline  
15 hydrochloride, the official name of the drug. We select  
16 these suppliers whom we wish to answer our quotations, and  
17 we send -- there are some six suppliers to whom we submit  
18 the request for quotations.

19 THE CHAIRMAN: You only call for tenders  
20 from suppliers in whom you have confidence?

21 PROF. SUMMERS: That is right, sir, yes.

22 MR. WHITELEY: With respect to the recommenda-  
23 tion regarding naming of drugs, do you think it is possible  
24 for Canada alone to proceed along the course you suggest?

25 PROF. SUMMERS: It would be possible. How  
26 practical it would be is another thing. Knowing as you  
27 well do, sir, that we are more or less the meat in the  
28 sandwich between what happens in Great Britain and what  
29 happens in the United States, and we are faced right now  
30 with drugs with two official names.



1 I am thinking of the drug marketed under  
2 the trade name Demerol, which is an analgesic preparation,  
3 which in the British Pharmacopoeia is called Pethidene,  
4 and this in the United States Pharmacopoeia is called  
5 Piperidine Hydrochloride. Perhaps the addition of another  
6 name would merely muddy the water.

7 Also you must take into consideration that  
8 the World Health Organization is attempting to introduce  
9 some degree of agreement on generic names. The only  
10 problem is what they eventually produce is a compromise  
11 and usually is completely unsuitable in that it does not  
12 meet the requirements we have specified.

13 MR. WHITELEY: I was thinking of the litera-  
14 ture on the drugs. A great part of our literature came  
15 from both the United Kingdom and the United States, and  
16 if Canada launched a course of selecting its own name,  
17 would this literature be as valuable to those making use  
18 of the preparations if you had a different naming system  
19 in Canada?

20 PROF. SUMMERS: In actual fact I don't think  
21 we are asking for a different naming system. We are asking  
22 Canadians to follow the same procedure which is now  
23 followed in the United Kingdom and which has now been  
24 proposed for the United States. These are the people who  
25 have been faced with this decision "Are we going to call  
26 it what the British call it, or are we going to call it  
27 what the Americans call it, or if we really want to be  
28 independent, are we going to think of one of our own?".

29 This decision can be made, and we will have  
30 an official terminology which we can understand. At least



1 we should have a representation by a number of people on  
2 what the drug will be called. Somebody who will actually  
3 assign a name to the drug, and not merely accept or reject  
2 4 names which have been presented to them.

5 MR. WHITELEY: If the drug already had a  
6 name outside of Canada, what would be the effect of not  
7 following that name or choosing some other name? In how  
8 many cases would it be possible for Canada to initiate  
9 the name you put on it?

10 PROF. SUMMERS: This may only confuse the  
11 issue, but we have found where a generic or where a non-  
12 proprietary name has been used very early in the develop-  
13 ment of a drug and a great deal of investigation has taken  
14 place on this drug and has been reported in the literature  
15 using non-proprietary terminology, that the physician only  
16 knows and writes the non-proprietary terminology for this  
17 drug.

18 Immediately one thinks of drugs like  
19 Cortisone; how many prescriptions come in with proprietary  
20 names for Cortisone? The majority we get are for cortisone,  
21 which is the official name of the drug. The same thing  
22 is true of Bacitracin and Neomycin, and in a number of  
23 drugs which had more or less a long-development period.

24 In order for a name to gain wide acceptance  
25 and understanding by the medical profession, it would be  
26 necessary for it to appear in the literature with sufficient  
27 frequency that they would become familiar with it. It is  
28 quite true that our medical literature today is largely  
29 either American or British, and we would be influenced  
30 by their nomenclature. We are now.



1 MR. WHITELEY: The main purpose of such a  
2 committee would be then really deciding whether to follow  
3 the American or British practices?

4 PROF. SUMMERS: I would suggest if you  
5 struck such a committee that we get the three together and  
6 decide on what we are going to call these things.

7 MR. WHITELEY: On an international aspect?

8 PROF. SUMMERS: I think that would be most  
9 desirable. The present situation is a little unclear at  
10 the moment, to put it mildly.

11 THE CHAIRMAN: There may be some problems  
12 where drugs are imported from an European country that  
13 does not use the same terminology?

14 PROF. SUMMERS: We have this problem today.

15 THE CHAIRMAN: You have it now, and several  
16 countries might adopt different names, and it would be  
17 extremely confusing?

18 PROF. SUMMERS: At least we feel some one  
19 in this country should say "let's put a name to this thing  
20 that we can use". We think it can be done. It would be  
21 largely a process I think of education rather than  
22 legislation, and maybe it will work.

23 THE CHAIRMAN: Has anyone any other questions?

24 MR. FRAWLEY: Doctor Summers, when you  
25 referred a moment ago to your personal practice, I suppose  
26 you were referring to your work in the fine new University  
27 Hospital in Saskatoon?

28 PROF. SUMMERS: Sir.

29 MR. FRAWLEY: How extensive is the use of  
30 the formulary system in Canadian hospitals?



1           PROF. SUMMERS: I have no precise knowledge  
2 of this, sir. I would say reasonably extensive, particularly  
3 among the larger hospitals which employ pharmacists.

4           For your information this is also an  
5 increasing practice in many of the small hospitals in  
6 Saskatchewan where we use the Regional Hospital Council  
7 system, and have a regional hospital pharmacy. We have  
8 found it is quite possible to put this system into practice  
9 in many of our smaller hospitals who have medical staffs  
10 as small as two or three members.

11           MR. FRAWLEY: You are president of the  
12 Canadian Society of Hospital Pharmacists?

13           PROF. SUMMERS: No, sir.

14           MR. FRAWLEY: No, no, you are a representative  
15 of that society on the Council of the Canadian Pharma-  
16 ceutical Association?

17           PROF. SUMMERS: Yes, sir.

18           MR. FRAWLEY: But you have a pretty broad  
19 knowledge of the formulary system and its use in hospitals  
20 in Canada generally?

21           PROF. SUMMERS: I have a precise knowledge  
22 of its use in my own hospital, yes.

23           MR. FRAWLEY: Coming over into the province  
24 of Alberta, we know the formulary system is used in the  
25 University Hospital. Is it used in the Royal Alexandra?

26           PROF. SUMMERS: I have no idea.

27           MR. FRAWLEY: Or in the General Hospital?  
28 Do you know in Calgary whether it is used in the General  
29 City Hospital?

30           PROF. SUMMERS: No.





1 MR. FRAWLEY: I don't know either, and I  
2 just wondered how general the formulary system was. I  
3 did understand that in a general way it was almost  
4 universally practised now in large hospitals such as your  
5 University Hospital in Saskatoon and ours in Edmonton,  
6 Alberta.

7 PROF. SUMMERS: I would say it was univer-  
8 sally used in the progressive hospitals.

9 THE CHAIRMAN: Are you admitting there are  
10 any others?

11 MR. FRAWLEY: Hospitals such as yours ask  
12 for bids for its drug supplies?

13 PROF. SUMMERS: For some of its drugs; for  
14 a very limited number of its drugs.

15 MR. FRAWLEY: Then the practice of calling  
16 for tenders is not a general practice? It is the  
17 exception?

18 PROF. SUMMERS: This calling for tenders  
19 on drugs, where it is convenient to do so, yes. Now, you  
20 must realize, Mr. Frawley, it would be a bit ridiculous  
21 to call for tenders on 50 capsules or tablets, but in order  
22 for tendering to be effective, one must buy in quantities  
23 exceeding one thousand dosage units of any given drug,  
24 even though it may not be -- if you are thinking of dollar  
25 volume wise I would suggest, yes, the majority are tendered.  
26 If, on the other hand, you are speaking about individual  
27 drugs, I would say certainly not because the number of  
28 drugs which I buy on tender would be less than 20.

29 MR. FRAWLEY: Let's take it with respect  
30 to the three large groups with which this Commission seems



1 to have been most concerned. I am referring to the  
2 antibiotics, the corticosteroids and the ataractics or  
3 tranquilizers.

4 PROF. SUMMERS: You can't take a group.  
5 Let's take specific drugs within the group, because even  
6 within these groups there are specific drugs which are  
7 supplied by only one individual manufacturer.

8 MR. FRAWLEY: Yes. Let's take the group  
9 of antibiotics. I think you said to the Chairman that  
10 you do call for bids -- perhaps I will put the question:  
11 Do you call for bids on tetracycline hydrochloride?

12 PROF. SUMMERS: Yes, sir.

13 MR. FRAWLEY: Do you call for bids on  
14 chloramphenicol?

15 PROF. SUMMERS: Yes, sir.

16 MR. FRAWLEY: Do you call for bids on  
17 chlorotetracycline, which I see by this document is the  
18 brand name of Lederle's Aureomycin.

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/dpw

1                   PROF. SUMMERS: No, we don't sir. This  
2 drug is the one that is used at a rate of approximately  
3 10 to 12 capsules a month. To call for bids on such a  
4 low quantity would be ridiculous.

5                   MR. FRAWLEY: Do you call for bids on oxy-  
6 tetracycline?

7                   PROF. SUMMERS: No sir. For the same  
8 reason.

9                   MR. FRAWLEY: I may be wrong, is that simply  
10 Pfizer's Terramycin or are there other oxytetracyclines?

11                  PROF. SUMMERS: Pfizer's do manufacture oxy-  
12 tetracycline under the trade name of Terramycin, yes sir.

13                  MR. FRAWLEY: Do you know of any other  
14 manufacturer manufacturing oxytetracycline under some  
15 other name?

16                  PROF. SUMMERS: No one manufacturing it as  
17 such. I know other people who market it.

18                  MR. FRAWLEY: Market it under the name of  
19 oxytetracycline?

20                  PROF. SUMMERS: Yes sir.

21                  MR. FRAWLEY: Now do you call for bids on  
22 Erythromycin?

23                  PROF. SUMMERS: No sir.

24                  MR. FRAWLEY: Do you call for bids on the  
25 cortosteroids?

26                  PROF. SUMMERS: Just a moment, let's go back  
27 on the Erythromycin. Here we must be careful because there  
28 are a number of salt forms of Erythromycin. There is  
29 Erythromycin sulfate and we also now have lauryl sulfate  
30 salts of Erythromycin. These salts of the drug make a



1 vast difference in the rate at which this drug is absorbed  
2 and you cannot compare the different salts of the same  
3 basic drug and consider them all synonymous so when you  
4 get into a drug such as Erythromycin one must be very  
5 careful to specify the salts and to supply the salt  
6 called for by the physician on his prescription.

7 MR. FRAWLEY: You mean when you are thinking  
8 of your supply of Erythromycin you call for the bids by  
9 a more restricted name, by a trade name?

10 PROF. SUMMERS: That is right sir. As each  
11 manufacturer puts out a different salt, and its use will  
12 be limited and for this reason it is not an economical  
13 operation to call for bids on this drug.

14 MR. FRAWLEY: I see that Upjohn seems to put  
15 it out under a brand name, same as what you call an  
16 official name, Upjohn manufactures an Erythromycin, Lilly  
17 manufactures Ilotycin.

18 PROF. SUMMERS: Ilotycin and Ilosone. Here  
19 is a very real difference. Ilotycin is the lauryl sulfate  
20 salt whereas Ilosone is not. Therefore you cannot say that  
21 Ilotycin and Ilosone are the same. They are absorbed at  
22 different rates. This could produce significantly diffe-  
23 rent clinical effects.

24 MR. FRAWLEY: When you want some penicillin  
25 G you call for bids for them?

26 PROF. SUMMERS: Yes, we do, and here we have  
27 about 20 or 30 different preparations of penicillin G and  
28 we call for bids on these which are used in large quanti-  
29 ties.

30 MR. FRAWLEY: Now you call for bids on the



1 cortosteroids for Prednisone?

2 PROF. SUMMERS: Prednisone, yes.

3 MR. FRAWLEY: Prednisolone?

4 PROF. SUMMERS: No, we don't use this - it  
5 is used in limited quantities only.

6 MR. FRAWLEY: Because it is used in limited  
7 quantities how do you obtain your supplies of Prednisolone?

8 PROF. SUMMERS: Directly from the manufactu-  
9 rer, or if it's a small quantity, from a local wholesaler.

10 MR. FRAWLEY: The same as dexamethasone?

11 PROF. SUMMERS: Same what sir?

12 MR. FRAWLEY: Same procedure?

13 PROF. SUMMERS: It is ordered directly from  
14 the manufacturer, yes sir, because of its extremely  
15 limited use.

16 MR. FRAWLEY: In tranquilizers, generally,  
17 you follow the same pattern? That is, those that are used  
18 more frequently you call for bids?

19 PROF. SUMMERS: Tranquilizers are not a  
20 problem. We do not seem to use a great many of them sir.  
21 We don't call for bids - we do not call for bids on any  
22 tranquilizers, no.

23 MR. FRAWLEY: Your procedure there is  
24 speaking of the University Hospital, but your mental insti-  
25 tutions would probably have a different procedure?

26 PROF. SUMMERS: I have no idea sir.

27 MR. FRAWLEY: Now generally speaking why do  
28 you call for bids for these drugs that you decide you need  
29 in sufficient quantities?

30 PROF. SUMMERS: We obtain the most





1 satisfactory price for drugs of the highest quality.

2 MR. FRAWLEY: In order to have the manufac-  
3 turers and suppliers bidding against each other, with the  
4 almost obvious result that you feel you get a better price.  
5 That is correct, is it, I suppose?

6 PROF. SUMMERS: Were you making a statement?

7 MR. FRAWLEY: I am asking you a question.

8 PROF. SUMMERS: What was your question?

9 MR. FRAWLEY: Is that why you do it? You  
10 said you get a better price as a result of manufacturers  
11 receiving the bids, bidding against one another so that  
12 you will ultimately select the cheapest price of all the  
13 bids?

14 PROF. SUMMERS: Yes.

15 MR. FRAWLEY: Do you find when you do receive  
16 the bids that you get a variety of prices?

17 PROF. SUMMERS: Yes sir.

18 MR. FRAWLEY: For instance, if you call for  
19 any one of them I have mentioned, you find that, generally  
20 speaking, the bids come in at a variety of prices?

21 PROF. SUMMERS: Yes sir.

22 MR. FRAWLEY: And I suppose you use the  
23 cheapest, use the lowest price?

24 PROF. SUMMERS: Yes, but remember we select  
25 the suppliers before we start. This means if he does  
26 submit the lowest bid, he automatically gets it. If I  
27 have no knowledge of the man, I do not send him a request  
28 for a quotation.

29 MR. FRAWLEY: I am sorry I missed the last  
30 part of that answer.



1                    PROF. SUMMERS: If I have no knowledge of  
2 the reputation of the supplier, I do not request a quota-  
3 tion from him.

4 MR. FRAWLEY: Now when you are selecting,  
5 you said in your evidence in your principal statement,  
6 only six are asked to submit bids?

7 PROF. SUMMERS: That is for tetracycline  
8 hydrochloride.

9 MR. FRAWLEY: Now are there any other manufac-  
10 turers or suppliers of tetracycline hydrochloride other  
11 than the six?

12 PROF. SUMMERS: Yes sir.

13 MR. FRAWLEY: So that means there must be  
14 some others that you do not send tenders to?

15 PROF. SUMMERS: Oh yes.

16 MR. FRAWLEY: Are there many more than six?

17 PROF. SUMMERS: I have no idea sir.

18 MR. FRAWLEY: Probably there are a number  
19 of them?

20 PROF. SUMMERS: I don't know. You see sir,  
21 we live in Saskatchewan and a great many of the smaller  
22 manufacturers do not have representatives and these manu-  
23 facturers are not known to us. We are unable to go down  
24 and have a look at their plants and therefore we do not  
25 even know they exist in many cases.

26 MR. FRAWLEY: So you then, or do you, limit  
27 yourself to those manufacturers and suppliers that have  
28 representatives in Saskatchewan?

29                    PROF. SUMMERS: Not necessarily.

30 MR. FRAWLEY: I just wondered. I was just



1 curious to know how you limit it. Why there were some you  
2 did not even send bids to?

3 PROF. SUMMERS: We answered this a little  
4 while ago. We said these are the people in whom I have  
5 confidence. Remember it is my professional reputation  
6 that is at stake here and if these people have my confi-  
7 dence, then I will accept a quotation from them.

8 MR. FRAWLEY: And I suppose that your list  
9 is increasing and decreasing over the years? There is no  
10 special six that you stick to?

11 PROF. SUMMERS: No.

12 MR. FRAWLEY: Nothing of that sort?

13 PROF. SUMMERS: No. No big six.

14 MR. FRAWLEY: Dr. Summers, what do you think  
15 about the supplying of drugs to out-patients? I take it  
16 that drugs supplied to out-patients in a hospital like  
17 yours in Saskatoon are supplied at a price less than what  
18 the retail pharmacist would charge?

19 PROF. SUMMERS: Well now, before we begin  
20 here, please tell me what you mean by "out-patients"?

21 MR. FRAWLEY: A patient who goes to an out-  
22 patient department and is invited there - I don't know too  
23 much about it. You know infinitely more about it than I  
24 do. Perhaps a poor person. Whoever are the persons who  
25 go to out-patient sections of the large hospitals like  
26 yours.

27 PROF. SUMMERS: We do not have an out-patient  
28 department in the classical sense. Remember the reason  
29 why the original out-patient department was developed.  
30 It was developed by the Romans to treat the poor people,



1 the people who had no physician of their own and those  
2 went to the hospital to receive treatment.

3               This situation does not necessarily exist  
4 in the west and there are very few people in the west who  
5 do not have a private physician of their own to whom they  
6 will go. We are brought up in this atmosphere so we don't  
7 have an out-patient department in the classical sense that  
8 ~~this is a department for those who cannot afford medical~~  
9 service. We do have very specific diagnostic facilities  
10 which may be used for individuals with certain diseases,  
11 and I am thinking of the Saskatchewan Government Cancer  
12 Clinic; Saskatchewan Government Glaucoma Program where  
13 very competent medical men are employed. In this respect  
14 we do have an out-patient department. Does that answer  
15 your question?

16               MR. FRAWLEY: Yes, it does, but it certainly  
17 prompts another question. In your hospital, you were  
18 taking in a lot of territory there when you said in the  
19 west, do you not have an out-patient department or a  
20 clinic at which doctors will go and spend a day doing that  
21 work in the out-patient department? A doctor will leave  
22 his office and spend a day or half-a-day attending to that  
23 out-patient department? I am speaking of something I know  
24 a little bit about, the Ottawa Civic Hospital.

25               PROF. SUMMERS: We have no comparable  
26 situation to the Toronto General Hospital and the Ottawa  
27 Civic Hospital or something like this, the classical out-  
28 patient department. We use the term for the artificial  
29 out-patient department created for the purpose of teaching  
30 medical students and the patients who come here are not -



1 they are regular patients of the physician who says come  
2 up to the hospital and I will examine you and the students  
3 can look on while I do it.

4 Such people are free to take their prescrip-  
5 tions to the local retail pharmacy. We do fill some out-  
6 patient prescriptions, however.

7 MR. FRAWLEY: Mr. Chairman, I seem to be a  
8 little stumbling about this questioning. Of course this  
9 is the very first time I have seen it. I am just trying  
10 to do the best I can and ask for clarification.

11 PROF. SUMMERS: You are asking for clarifica-  
12 tion on a most confused subject, on those out-patient  
13 services.

14 MR. FRAWLEY: Yes. Please Dr. Summers, I  
15 am not casting the slightest reflection on you.

16 PROF. SUMMERS: I realise that sir. I was  
17 just trying to help you.

18 MR. FRAWLEY: I am referring to the task of  
19 endeavouring to ask a few questions in cross-examination  
20 having only seen the document this morning, and if it  
21 wasn't for my good friend, Mr. Cook, I would be sitting  
22 without even the opportunity of looking at it.

23 PROF. SUMMERS: I must apologize to you.  
24 This is my fault because I just completed the document at  
25 12 o'clock last night. Therefore, it was a little diffi-  
26 cult to have it in your hands. I must apologize to you  
27 Mr. Frawley.

28 THE CHAIRMAN: We are all in the same boat.

29 MR. FRAWLEY: I do want to ask you one more  
30 question. I was asking Dr. Schechter this at Ottawa -





1 take one of these cortosteroids, say, dexamethasone. This  
2 is sold by trade name apparently by three people, Merck,  
3 Decadron; Schering, Deronil; Ciba, Gammacorten. Does  
4 that conform to your understanding of the way in which  
5 dexamethasone is put on the market?

6 PROF. SUMMERS: Yes sir.

7 MR. FRAWLEY: Suppose I wanted to buy dexamethasone  
8 by its generic or non-proprietary name; would  
9 there be any place where you could buy it as dexamethasone?

10 PROF. SUMMERS: Yes sir. I can buy it from  
11 Schering or Merck or Ciba as dexamethasone.

12 MR. FRAWLEY: Wouldn't it be Decadron (dexamethasone)?  
13 It isn't dexamethasone (Decadron), if you  
14 bought it from Merck?

15 PROF. SUMMERS: It could be if I specified  
16 that this drug shall come labelled as dexamethasone.  
17 This is the way they would send it to me.

18 MR. FRAWLEY: They wouldn't have the name  
19 Decadron on it at all?

20 PROF. SUMMERS: If I so specified, if I was  
21 so particular and this is what I wanted on it, and said I  
22 want 5,000 of this drug and specified the manner in which  
23 the label should be drawn up, I am quite sure they would  
24 supply it so labelled.

25 MR. FRAWLEY: Now then he would prescribe  
26 in your hospital, in your formulary - presume you have a  
27 physician who had a patient suffering from some inflammatory  
28 arthritic condition or something that this drug  
29 would help, would he prescribe dexamethasone?

30 PROF. SUMMERS: I have no idea sir. He may



1 call it Decadron or dexamethasone, whatever name that he  
2 happens to remember and is associated with this particular  
3 steroid which produces certain clinical responses, this  
4 name he will call it.

5 MR. FRAWLEY: Let me understand the discre-  
6 tion left to the hospital pharmacist. If he prescribed  
7 dexamethasone the pharmacist could supply to the patient  
8 any one of those drugs or any one of the brands that I  
9 have indicated, Decadron, Deronil, Gammacorten?

10 PROF. SUMMERS: Yes, and they can go farther.  
11 If he said, if he specified Gammacorten and I had Decadron  
12 in stock, I would supply Decadron.

13 MR. FRAWLEY: That is my next question I  
14 was going to ask, dealing with the generic. If he pres-  
15 cribed dexamethasone ---

16 PROF. SUMMERS: Dealing with the generic  
17 what?

18 MR. FRAWLEY: Dealing with the generic name  
19 first. If he prescribed or he ordered dexamethasone the  
20 hospital pharmacy could supply either the dexamethasone  
21 you told us about a moment ago with no brand label on or  
22 Decadron if you had some of that, or Gammacorten?

23 PROF. SUMMERS: Yes.

24 MR. FRAWLEY: Now taking triamcinolone,  
25 which is retailed as Aristocort and Squibb's Kenacort, is  
26 there a possibility of substituting triamcinolone for dexamethasone?  
27

28

29

30



1 PROF. SUMMERS: Oh, no.

2 MR. FRAWLEY: So trimacinolone....

3 PROF. SUMMERS: Those are entirely different  
4 drugs, absolute completely different chemical entity,  
5 and no pharmacist, no competent pharmacist would even  
6 suggest such a thing.

7 MR. FRAWLEY: He wouldn't have triamcinolone  
8 for decadron. He might substitute deronil or gammacorten.  
9 Certainly, Aristocort or Kenacort. There is only one thing  
10 I would like to ask you to clear up for me. These names,  
11 brand and generic and chemical -- I have this folder of  
12 the N.S.D. for decadron.

13 PROF. SUMMERS: About this particular drug  
14 or the whole field?

15 MR. FRAWLEY: I am only asking about this  
16 illustration. I have this circular which talks about  
17 decadron and .....

18 PROF. SUMMERS: Dexamethasone.

19 MR. FRAWLEY: The generic or non-proprietary  
20 name?

21 PROF. SUMMERS: Dexamethasone.

22 MR. FRAWLEY: The brand name?

23 PROF. SUMMERS: Decadron.

24 MR. FRAWLEY: There is another name here.

25 PROF. SUMMERS: Which one is that?

26 MR. FRAWLEY: I will read it to you, Decadron,  
27 dexamethasone is 9 alpha fluro, and 16 alpha methy-  
28 prednisolone NSD.

29 PROF. SUMMERS: Good for you, I can't even  
30 say it.



1 MR. FRAWLEY: What is that?

2 PROF. SUMMERS: That is the chemical name.

3 MR. FRAWLEY: Now, we have the brand,  
4 generic and chemical names for this drug and that applies  
5 to all drugs, generally speaking?

6 PROF. SUMMERS: Generally speaking. Of  
7 course one may also have an official name.

8 MR. FRAWLEY: Official on top of the three.  
9 There is nothing you can tell us as an example for this  
10 one?

11 PROF. SUMMERS: The official name, and I  
12 notice this has come up in the testimony. It is a mis-  
13 conception that the official name and non-proprietary name  
14 is synonymous. That is not necessarily so. The drug only  
15 becomes, its nomenclature when it becomes official as in  
16 the British Pharmacopoeia or the United States Pharmacopoeia  
17 or the National Formulary of the United States. It is  
18 then referred to as an official drug. It is not official  
19 until such time as it appears in this compendium and is  
20 approved by the commission which forms such compendium.

21 MR. FRAWLEY: Dealing with the suppliers  
22 that you send bids to, the University Hospital in Edmonton  
23 has sent me documents from which I just judge -- I  
24 don't know what I could do, I infer that these deal with  
25 obtaining prices from three suppliers who are generally  
26 known as suppliers of the generic drugs, if you will let  
27 me say that.

28 PROF. SUMMERS: I will let you, yes. I  
29 won't agree. There is no such thing as the generic drug.  
30 There is a generic name.



1 MR. FRAWLEY: Non-proprietary is better?

2 PROF. SUMMERS: Non-proprietary -- what are  
3 you describe, a drug or a name?

4 MR. FRAWLEY: The drug, they are calling  
5 for bids. This hospital is calling for bids. You say they  
6 call for them under their ordinary non-proprietary name?

7 PROF. SUMMERS: Yes.

8 MR. FRAWLEY: I am only getting to the names  
9 of the suppliers. I am assuming that the University  
10 Hospital in Edmonton, assuming from this document, which  
11 sometime I hope to fulfil my undertaking and file it as  
12 an exhibit, I take it from that document they call for  
13 bids from three names who are known as firms who supply,  
14 or maybe, manufacture, depending on the meaning of the  
15 word manufacture, non-proprietary drugs, drugs with non-  
16 proprietary names. Their names are Starkman, Gilbert and  
17 Empire and they all have the distinction of carrying on  
18 business in the City of Toronto. Do you include them  
19 when bids are sent out?

20 PROF. SUMMERS: For what?

21 MR. FRAWLEY: For any drug, in drugs?

22 PROF. SUMMERS: I don't.

23 MR. FRAWLEY: You don't use their names in  
24 calling for bids for any drugs of any kind?

25 PROF. SUMMERS: No.

26 MR. FRAWLEY: Any special reason for that?

27 PROF. SUMMERS: Except I don't know who  
28 these people are. I don't know their reputations. They  
29 must be relatively new in the manufacturing industry. I  
30 have heard of them, certainly.





1 MR. FRAWLEY: You don't know any of these  
2 men's names?

3 PROF. SUMMERS: I know the men's names,  
4 but I don't know of their plants. The finest products are  
5 used in our hospital. I haven't seen them manufacture  
6 their products. I haven't had an opportunity to see their  
7 methods or go through and check their control facilities.  
8 I have been in pharmacy for twenty odd years. I haven't  
9 seen the manufacturing places of these people.

10 MR. FRAWLEY: But you do know them, you know  
11 who they are?

12 PROF. SUMMERS: I don't know who Empire are  
13 except I know there is a firm called Empire. I don't know  
14 how they manufacture. I don't know where they import  
15 from. I merely know there is a firm in Toronto called  
16 Empire because I have seen this in advertisements. I  
17 don't think you can classify that as knowing a firm. The  
18 only thing I know of Starkman, I know it is an eminent  
19 pharmaceutical retail firm in Toronto. That is all I know  
20 about it.

21 MR. FRAWLEY: All you know, it is a retail  
22 firm in Toronto?

23 PROF. SUMMERS: Yes.

24 MR. FRAWLEY: Would you be surprised to  
25 know he is supplying to one doctor in Edmonton who was good  
26 enough to send -- I didn't ask him for it -- his bill from  
27 Starkman. I think he ran up a bill in one month of \$400.00  
28 for drugs and supplies. To be perfectly frank that is  
29 hardly a retail druggist operating in Toronto. He must  
30 operate a fully Canadian business, Starkman, I put it to



1 you. You say you knew him as a retail....

2 PROF. SUMMERS: A retail firm in Toronto.

3 MR. FRAWLEY: A retail firm in Toronto.

4 When I told you this doctor is buying \$400.00 worth of  
5 drugs and certain surgical and medical supplies, I put it  
6 to you it follows he is something more than a retail  
7 druggist.

8 PROF. SUMMERS: A retail pharmacist, a  
9 concern in Toronto. What you have told me doesn't mean  
10 anything more to me.

11 MR. FRAWLEY: You know him as a retail  
12 pharmacist in Toronto. You mean you don't know whether  
13 he was operating as anything else but that?

14 PROF. SUMMERS: Yes.

15 MR. FRAWLEY: The other name is Gilbert.  
16 Do you know Mr. Gilbert?

17 MR. SUMMERS: I know Mr. Gilbert personally,  
18 yes.

19 MR. FRAWLEY: You have never asked Mr.  
20 Gilbert for any bids?

21 PROF. SUMMERS: No.

22 MR. FRAWLEY: That is because you don't know  
23 anything about his plant?

24 PROF. SUMMERS: I wouldn't say that entirely,  
25 sir, what do you want to know from me?

26 MR. FRAWLEY: I want to know the extent to  
27 which you are reaching out and using the facilities of  
28 firms who make it a business to use generic.

29 PROF. SUMMERS: I reach out and contact all  
30 those firms who sell drugs under their generic names. This



1 includes every manufacturer in Canada in whom I have  
2 confidence.

3 MR. FRAWLEY: We will leave it this way,  
4 you have no confidence in these three people, Gilbert,  
5 Starkman and Empire?

6 PROF. SUMMERS: You said it.

7 MR. FRAWLEY: I am asking you.

8 PROF. SUMMERS: I will not answer that, sir.

9 MR. COOK: This group are sort of nephews  
10 of the Association I represent. Therefore, I think I may  
11 speak for them. I have sat patiently through this examina-  
12 tion. When it reaches the point where the witness is  
13 expected to make a comparison between particular name  
14 manufacturers and is invited to praise one to the detriment  
15 of the other, I don't think that is a proper question of  
16 the witness nor a matter with which the Commission is  
17 concerned. I think that I should ask that the cross-  
18 examination along that line be restricted.

19 THE CHAIRMAN: I think the witness has  
20 answered the question, which I took to be directed towards  
21 ascertaining why -- he was referring to a particular firm,  
22 that is true. I think it was directed to ascertain why a  
23 number of firms who manufacture and sell under generic  
24 names only, why they are not bidding; is that correct?

25 MR. FRAWLEY: Yes, Mr. Chairman. I am sure  
26 my friend's objection was well intended, but I do want to  
27 say this: There has been a great deal of discussion before  
28 this Commission in all the sittings I have attended with  
29 regards to the question of generic or non-proprietary names  
30 as against brand names. It has been discussed from many,



1 many angles. I thought it was my duty in view of some of  
2 the representations made by the Government of Alberta to  
3 this Commission that we should inspect the whole question  
4 of generic name. It is no more pleasant to me to do than  
5 for my friend, Mr. Cook, to listen to it, to get into the  
6 realm of trying to distinguish between these people,  
7 Starkman, Empire and Gilbert and the ordinary manufacturers.  
8 I am only doing it because I think the Commission can't  
9 find out too much about this whole question about the value  
10 of generic names, the value of generic name drugs as  
11 against the value of brand name drugs. It is not because  
12 I desire to, it is not because I like to discuss personal  
13 matters with witnesses but I think I have no alternative  
14 but to do it. I think the Commission must know the value  
15 of the generic drug names and why it is not more used.

16                   PROF. SUMMERS: Every manufacturers markets  
17 his product under generic name. He must. The law says  
18 he must have the generic name on every package of every  
19 drug where such does exist. It is my prerogative to order  
20 any drug I use under its generic name. When you talk about  
21 the basis, I would refer you back to the statement I think of the  
22 most knowledgeable men in quality control in the whole  
23 of Canada, Dr. Morrell . He says: "The real point is  
24 who makes the drug and how it is made -- the control system  
25 that ensures careful and scientific testing for potency  
26 and stability." It goes on "When it comes to buying top  
27 quality drugs the things to check are the ability, facilities,  
28 personnel and conscience of the drug manufacturer".  
29 I submit to you that I don't know anything about the  
30 personnel of the firms that you have mentioned, nor do I --



1 it is not entirely true -- about the conscience, I will  
2 leave this up to you. I have evidence in some cases  
3 abilities are not to the standards I require for those who  
4 manufacture drugs which I purchase. About facilities,  
5 I haven't ever visited these particular plants. Does that  
6 answer your question, sir?

7 MR. FRAWLEY: Yes. Coming now to the Food  
8 and Drug Directorate, I should ask this and then I will  
9 be finished with my questions. What would be difficult  
10 about the Food and Drug Directorate undertaking this  
11 responsibility which they don't now undertake and putting  
12 the stamp of approval on non-proprietary drugs so that  
13 it could go out without those disabilities you have called  
14 to our attention?

15 PROF. SUMMERS: I don't think that is a  
16 function of Government. It is the responsibility of the  
17 individual manufacturer. It is the responsibility of  
18 Government to set such standards as it deems are adequate  
19 to protect the people of this country and to see that the  
20 manufacturer observes his obligations and responsibilities.  
21 Now, this can be done by inspecting these plants. No  
22 knowledgeable person in the field of pharmacy could walk  
23 into a plant and spend a day with them and not learn more  
24 and know more about the quality of the product which they  
25 produce than analytically, by testing they could learn in  
26 five years. It is the products that are produced ....

27 MR. FRAWLEY: Let us be very .....

28 PROF. SUMMERS: You can't inspect quality  
29 into the product. It must be built in by knowledge and  
30 ability.





1 MR. FRAWLEY: Let us be specific about it.  
2 If chloramphenicol or tetracycline hydrochloride were  
3 imported from Japan or Denmark or Italy and brought into  
4 Canada in bulk and were available to the public at prices  
5 cheaper than the names of Lederle, Bristol, Pfizer, Squibb  
6 and Upjohn-- assuming they were made available, then would  
7 it not be worthwhile to have the disabilities you mentioned  
8 with regard to the Japanese or Italian drugs cured by  
9 quality control federally?

10 PROF. SUMMERS: Certainly not, the individual fir  
11 or manufacturer is responsible for bringing these drugs  
12 in. In fact the firms which you have mentioned do import  
13 drugs into Canada from countries outside of Canada. Many  
14 of the preparations of our basic drugs and chemicals are  
15 imported into this country. If you don't, you are out of  
16 luck. All the large companies do.

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JW/dpw

1 Now, the majority of our reputable manufac-  
2 turers import the bulk of the basic drugs and chemicals  
3 which they use. If it is the responsibility of these  
4 people - let us put it this way - it is the respon-  
5 sibility of any supplier of drugs to observe his respon-  
6 sibilities in assuring the quality of the products which  
7 he sells.

8 He must assume, in other words, what he is  
9 doing is, "I bring in a batch of stuff. If the Government  
10 is responsible for it, I will sell it and if they catch me,  
11 that is fine. All I have to do is dump it in the creek.  
12 If they don't, all right, it is out on the public".

13 This is what happens. I don't want my taxes  
14 used for paying for a control laboratory that should be  
15 put up by someone else, and I don't think you do either,  
16 Mr. Frawley.

17 MR. FRAWLEY: Dr. Summers, as you look down  
18 the road, what would you see in the future in the way of  
19 reduced drug prices? I am putting it to you if we were  
20 able to get the non-proprietary drugs into the hands of  
21 the public by prescription, would they be paying less for  
22 their drugs?

23 PROF. SUMMERS: There is no such thing as a  
24 non-proprietary drug.

25 MR. FRAWLEY: This is very specific, and  
26 perhaps it is as well for me to illustrate it. If you will  
27 assume with me that the list price of Achromycin capsules  
28 is \$42.40 less 40%, or rather, that the list price is  
29 \$42 and therefore that the price to the doctor or the  
30 pharmacist is \$42 less 40% and assume that is Lederle's



1 product ---

2 PROF. SUMMERS: You can assume it if you  
3 like. I frankly don't know.

4 MR. FRAWLEY: Of course, you see that makes  
5 the whole thing difficult. I suppose that the Commission  
6 by a personal inspection will have to satisfy themselves,  
7 but will you assume with me for the purpose of my question  
8 - and I am not asking you to accept it because you say you  
9 don't know?

10 PROF. SUMMERS: All right.

11 MR. FRAWLEY: Subject to what the Commission  
12 learns afterwards by a personal inspection, assume with me  
13 that the Commission by going into the Gilbert plant finds  
14 that what he is advertising there at \$42.08 to the doctor  
15 is actually Lederle's Achromycin, 250-milligrams. Assume  
16 that. Are you troubled about my question?

17 PROF. SUMMERS: I am not sure what I am  
18 assuming.

19 MR. FRAWLEY: Assume what I find listed in  
20 Gilbert's catalogue at page 25 at \$42.08 is the list price  
21 for Lederle's Achromycin.

22 PROF. SUMMERS: Yes.

23 MR. FRAWLEY: And then assume that I find on  
24 page 25, at \$18 a 100, Gilbert's Tetracycline hydrochloride  
25 capsules of the same dosage strength, that is to start  
26 with quite a difference in the price, isn't it?

27 PROF. SUMMERS: The best thing you can do  
28 is show it to me and I will know what you are talking  
29 about.

30 MR. FRAWLEY: Yes.



1 PROF. SUMMERS: What are the prices?

2 MR. FRAWLEY: They are to doctors. I

3 would think that professional price means price to doctors.

4 PROF. SUMMERS: We will assume that.

5 MR. FRAWLEY: I am only asking you to look

6 at the difference in price, that is all. I am asking you

7 to look at \$42 as against \$18. That is all.

8 PROF. SUMMERS: Yes.

9 MR. FRAWLEY: And I take it when you look

10 at the \$18 a 100 for tetracycline hydrochloride capsules

11 of 250-milligram dosage, you will probably say to me you

12 don't know anything about the origin of it, you don't know

13 anything about the quality of it or the way in which it

14 was manufactured, and so on. I assume that I am right in

15 assuming that?

16 PROF. SUMMERS: What?

17 MR. FRAWLEY: That you would have some

18 misgivings about the product that is being offered at \$18

19 a 100?

20 PROF. SUMMERS: Yes.

21 MR. FRAWLEY: That is what I understood from

22 your sentence as far as the names are concerned, that is

23 the non-proprietary name.

24 PROF. SUMMERS: Yes.

25 MR. FRAWLEY: Tetracycline H.C.L. and Achro-

26 mycin is a tetracycline, H.C.L.

27 PROF. SUMMERS: Yes.

28 MR. FRAWLEY: So it is the same, or a very

29 comparable product?

30 PROF. SUMMERS: Right.



1 MR. FRAWLEY: Assume that they are comparable,  
2 and assume that one has been selling at \$18 a 100 to a  
3 certain class of the public, and the other is being  
4 offered at \$42 to the same class of the public. I put it  
5 to you, have you got anything to suggest as to the manner  
6 in which the public might obtain the benefit of the lower  
7 price?

8 PROF. SUMMERS: Yes.

9 MR. FRAWLEY: Well, how?

10 PROF. SUMMERS: Well, it is very simple.  
11 If the physician writes a prescription in which he speci-  
12 fies "Tetracycline, hydrochloride (Gilbert only)", then  
13 the prescription would be filled with that specific brand  
14 of tetracycline hydrochloride.

15 MR. FRAWLEY: And would you say that that  
16 would be a proper or an improper thing to do with respect  
17 to the medical profession?

18 PROF. SUMMERS: It is the prerogative of the  
19 physician, if he so chooses to do this, if he so chooses,  
20 to specify. I would submit that when he is doing this,  
21 he is in effect doing the same thing as he does when he  
22 writes "Achromycin", because when he does that, what he  
23 is doing is specifying "Lederle's brand of tetracycline  
24 hydrochloride". What is the difference between saying  
25 "Achromycin" and "Tetracycline hydrochloride (Jules Gilbert  
26 only)"?

27 MR. FRAWLEY: What is the difference?

28 PROF. SUMMERS: Nothing.

29 MR. FRAWLEY: A lot of money to the patient,  
30 that is the difference.





1 THE CHAIRMAN: Was there something wrong  
2 about it?

3 PROF. SUMMERS: Yes, we are not talking  
4 about prices.

5 THE CHAIRMAN: This is not a matter of  
6 choice why the physician writes a prescription that costs  
7 \$42.08, and if he writes over this \$18, and if the physi-  
8 cian is satisfied with the cheaper one, that it will do the  
9 job, he may feel inclined to write it, isn't that what you  
10 mean?

11 PROF. SUMMERS: Yes sir.

12 MR. FRAWLEY: I am sorry I have taken a  
13 great deal of time.

14 THE CHAIRMAN: One further question appeared  
15 to me, Mr. Summers. You mentioned when you called for  
16 tenders you got a variety of tender prices?

17 PROF. SUMMERS: That is right.

18 THE CHAIRMAN: Is it common that there is  
2 quite a wide variation in the tender price?

20 PROF. SUMMERS: No sir. It usually varies  
21 only a few cents per 100.

22 THE CHAIRMAN: Another question arises, and  
23 I don't know whether you can answer it. Are you in a  
24 position to state whether the tender prices you get when  
25 you call for tenders are around the same level or slightly  
26 lower or substantially lower than the prices you would get  
27 if you called for the same product from the companies  
28 without the tender?

29 PROF. SUMMERS: I am sorry I cannot make a  
30 general statement on this because some of the drugs which



1 we purchase on tender or contract, are drugs which are not  
2 used outside hospitals, and therefore they are very speci-  
3 fic.

4 In some cases there is a fairly wide varia-  
5 tion between the tender price and what it would normally  
6 cost the retail pharmacist to buy. In other cases, the  
7 difference is but a few cents, and in some cases there  
8 is no difference other than that of subtracting the sales  
9 tax.

10 THE CHAIRMAN: Have you had any experience  
11 in buying a drug without calling for tenders, and then on  
12 another occasion calling for tenders on the same drug?

13 PROF. SUMMERS: Yes sir.

14 THE CHAIRMAN: And have you observed any  
15 variation in the price?

16 PROF. SUMMERS: Yes sir, not always.

17 THE CHAIRMAN: Is it very substantial?

18 PROF. SUMMERS: No, I would not say that.

19 I would have to examine our records to be precise. But  
20 as a general statement, it is usually not a wide difference,  
21 not a great difference.

22 THE CHAIRMAN: Not a great difference?

23 PROF. SUMMERS: Not a great difference from  
24 the price that the hospital normally would pay.

25 Do I make myself clear, because as you have  
26 stated, there are some drugs which by tradition are sold  
27 normally at low prices to the hospital, much lower than  
28 the retail pharmacist can obtain them for.

29 THE CHAIRMAN: Hospitals have certain advan-  
30 tages with regard to sales tax?



1 PROF. SUMMERS: Yes sir.

2 THE CHAIRMAN: Those are all the questions  
3 I have.

4 MR. HUME: Mr. Chairman, I wonder whether  
5 Mr. Frawley can just assist me, because in respect to the  
6 questions he asked, I have a question. I want to put a  
7 question to the witness. In quoting his price of \$18 as  
8 opposed to \$42.40, I am wondering whether Mr. Frawley has  
9 fallen into the error that the printer of that list inten-  
10 ded. I am wondering if on the \$42.40 price you quoted,  
11 you could take off the 40%, which brings it down to \$25.20.

12 MR. FRAWLEY: No, I endeavoured to make  
13 that clear to the witness. I think the \$42.40 must be  
14 less 40%.

15 PROF. SUMMERS: Yes.

16 MR. HUME: So that by comparing there as  
17 Mr. Frawley did, the \$42, something, as against the \$18,  
18 he really perhaps should have compared \$25.20 as against  
19 \$18.

20 PROF. SUMMERS: Yes, that is quite true,  
21 because I could purchase this particular drug at a much  
22 lower price from the original supplier. I would not pur-  
23 chase this drug from Gilbert because his price is much  
24 higher than Lederle charged for it.

25 MR. FRAWLEY: The \$42.08 and the \$18 are  
26 correct. If you are going to take 40% off \$42, take it  
27 off \$18 also. The \$42 stands up there against the \$18.  
28 There is no doubt about that at all.

29 I intend to file some more exhibits which  
30 will make that very, very clear.



1                    PROF. SUMMERS: Might I ask a question?

2 This \$42.40 is the price for the trade name product which  
3 Gilbert charges in actual fact. What you suggest is the  
4 physician must pay this price for the product. That is  
5 not right. If the physician bought the product direct  
6 from the manufacturer, he would pay a much lower price for  
7 it.

8                    THE CHAIRMAN: There has been some misunder-  
9 standing about that. I thought what Mr. Frawley was  
10 indicating was, doesn't the physician pay \$42.08 less 40%?

11                   PROF. SUMMERS: Only ---

12                   THE CHAIRMAN: And similarly if he bought  
13 the Gilbert product, he would pay \$10 less 40%.

14                   PROF. SUMMERS: Only under very specific  
15 conditions, only if both products were bought from the  
16 same company, only if they were both purchased from  
17 Gilbert. I submit that if the drug listed under its trade  
18 name were bought from its original manufacturer and not  
19 Gilbert, the physician would pay much less than \$42.40.

20                   MR. HUME: I would also like to suggest Mr.  
21 Frawley's \$18 less 40% reduces that price to \$10.80. In  
22 the document he just showed me, the price to hospitals is  
23 \$14.40, so I don't know why the retail pharmacist would  
24 pay less than the hospital. If you take 40% off \$18, that  
25 is \$7.20, and you are down to \$10.80.

26                   I think Mr. Frawley is using figures the  
27 way the person who prepared the catalogue intended them  
28 to be used. In the one column he is indicating the retail  
29 price in one case and the list price in the other case,  
30 and in the other column he is indicating something else..



1 MR. FRAWLEY: My friend, Mr. Hume, may be  
2 right. There is one thing about it, it is awfully hard  
3 to get costs, but prices are simple. The Commission or  
4 its investigators could go anywhere those prices are listed  
5 and find out about them. It is not very difficult.

6 THE CHAIRMAN: I think we won't go any far-  
7 ther in that argument on this point.

8 MR. HUME: There is one very minor point,  
9 Doctor, that might assist the Commission if you and I  
10 would clarify it. My name is Fred Hume and I represent  
11 the Manufacturers' Association. This is a non-contentious  
12 area, but in discussing with Mr. Frawley the purchasing  
13 of drugs in your hospital, I wondered if it would be of  
14 any assistance if you could firstly indicate what percen-  
15 tage, not the dollar volume - I realise you qualified that -  
16 what percentage of the available list of pharmaceutical  
17 products are bought by tender and what percentage are  
18 bought other than by tender?

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G/EMT/nm

1 PROF. SUMMERS: By actual name, yes. I  
2 specified it is less than some 25 products -- less than 25  
3 out of 7,776 which are listed in the Compendium.

4 MR. HUME: Just taking the individual  
5 inventory items, 25 out of some seven thousand?

6 PROF. SUMMERS: Yes.

7 MR. HUME: Of the others which are not  
8 bought -- the 25 products that are not bought by tender,  
9 are they single products -- I am getting a little out of  
10 my sphere here -- are they one-chemical products, or are  
11 they a compounding of other ingredients?

12 PROF. SUMMERS: No, in most cases they are  
13 single ingredients. As I said, I would have to look over  
14 the list and see actually what are there, and I can think  
15 of only one or two products that perhaps are purchased on  
16 tender which are compounds of two particular specific  
17 agents.

18 MR. HUME: I ask you an obvious question,  
19 and the answer may be obvious to you, but it is not to me,  
20 if a product, if a pharmaceutical product is made up of  
21 more than one ingredient; that is, a series of ingredients,  
22 would it be possible to call for it by tender without  
23 specifying the complete formula?

24 PROF. SUMMERS: It may be, because some of  
25 the products which contain more than one ingredient have  
26 been given official names in the British Pharmacopoeia and  
27 the United States Pharmacopoeia and in the National Formulary.

28 MR. HUME: So that you get the advantage  
29 then, Doctor, that even though it may be a compounding of  
30 products so that a simple generic classification such as



1 Mr. Frawley was using is not possible, there may still in  
2 addition be an official name that assists you in specifying?

3 PROF. SUMMERS: There may be. This does  
4 not happen very often, but these names do exist.

5 MR. HUME: Interchanging which you indicated  
6 on your formulary list, would relate I presume to dosage,  
7 single medication, single product, single chemical?

8 PROF. SUMMERS: Either single chemicals  
9 or preparations containing identical chemicals combined  
10 in the identical type of dosage form.

11 MR. HUME: Supposing the inactive ingredient  
12 was different in one case; a water soluble compound, and  
13 in another a petroleum base compound, would you inter-  
14 change in a case like that?

15 PROF. SUMMERS: Certainly not, because here  
16 the other thing would be different. I specified the dosage  
17 form would have to be identical and in the case which you  
18 have illustrated, the dosage form would not be identical.

19 MR. HUME: You, as a pharmacist in the  
20 hospital, if a prescription came in for, say, a trade name  
21 that had a water soluble base, you would not substitute that  
22 for something else on your formulary if you had the same  
23 pharmaceutical product but with another inactive ingredient?

24 PROF. SUMMERS: No, this makes a different  
25 preparation altogether.

26 THE CHAIRMAN: Mr. MacLeod, you have some  
27 questions?

28 MR. MacLEOD: Yes, sir.

29 THE CHAIRMAN: We will have a break now.

30 ---Short recess.



1 MR. MacLEOD: As a matter of interest, are  
2 you familiar with any of the products of McKesson and Robbins  
3 Incorporated, a United States drug firm?

4 PROF. SUMMERS: No, sir. I am not; not  
5 under that name.

6 MR. MacLEOD: McKesson and Robbins.

7 PROF. SUMMERS: They are a wholesale firm.

8 MR. MacLEOD: Now, in discussing some  
9 questions with Mr. Frawley at one point I think in respect  
10 to oxytetracycline sold under the trade name of terramycin,  
11 you said you did not know of any other manufacturer; you  
12 knew of other distributors of this drug? Is that correct?

13 PROF. SUMMERS: That is right, sir.

14 MR. MacLEOD: I just wanted to get clear  
15 what you meant by "manufacturer" there.

16 PROF. SUMMERS: In this particular case I  
17 was referring to the manufacturer of the basic drug.

18 MR. MacLEOD: Of the basic drug?

19 PROF. SUMMERS: Of the basic drug, yes.

20 MR. MacLEOD: So that these persons whom  
21 you referred to as suppliers, might actually prepare the  
22 dosage form in Canada.

23 PROF. SUMMERS: They well might, and within  
24 such meaning are considered as manufacturers, yes.

25 MR. MacLEOD: I just wanted to get clear  
26 your use of the term. Is the principal reason for using  
27 a formulary the proliferation of the names, of trade names?

28 PROF. SUMMERS: Largely, yes. Not only  
29 proliferation of trade names, but of actual drugs bearing  
30 the name.



1                   There is another very good reason for using  
2 a formulary. A formulary is an educational tool, and one  
3 of the chief functions of a formulary is to guide the  
4 physician by telling him what drugs are available under  
5 specific therapeutic categories. Thus if a physician wishes  
6 to use a hypnotic, he merely looks in the formulary and  
7 there listed under the hypnotics are a selection of drugs  
8 which may be used for that purpose.

9                   He then knows there are four or five drugs  
10 available, and what they are, and it gives him an opportunity  
11 to select one of those therapeutic agents from a list. This  
12 is the major purpose of a formulary.

13                  MR. MacLEOD: Yes. Now, as you mentioned  
14 also to Mr. Frawley, despite the fact that a product is  
15 sold under a brand name, it also carries the generic or  
16 official name?

17                  PROF. SUMMERS: Yes.

18                  MR. MacLEOD: I am just wondering why bother  
19 breaking it down to generic name.

20                  PROF. SUMMERS: I am sorry. I do not under-  
21 stand your question, sir.

22                  MR. MacLEOD: A brand name product, despite  
23 the brand is only something added to the generic name,  
24 isn't it?

25                  PROF. SUMMERS: It is the ---

26                  MR. MacLEOD: Does the use of the brand name  
27 create any difficulty?

28                  PROF. SUMMERS: It creates confusion in  
29 that there is more than one name for a specific drug used,  
30 and unless you know that it is a brand name of a specific



1 basic drug, sometimes you couldn't tell that the two brand  
2 names referred to a single therapeutic compound.

3 MR. MacLEOD: Is the brand name in that  
4 sense a source of confusion?

5 PROF. SUMMERS: It may be to some people.  
6 If you don't know, then certainly it confuses you, but if  
7 you do know your generic names and your brand names, you  
8 should not be too confused, no. If you do know.

9 MR. MacLEOD: The brand name of itself, as  
10 I understand it, frequently does not tell you anything  
11 about the nature of the drug?

12 PROF. SUMMERS: Yes, that is correct.

13 MR. MacLEOD: Now, you said something about  
14 combinations. Are there combinations, and combinations in  
15 this sense that certain are more or less standard and  
16 certain are special?

17 PROF. SUMMERS: Yes.

18 MR. MacLEOD: Like an A.P.C. tablet is a  
19 pretty standard classification?

20 PROF. SUMMERS: Yes.

21 MR. MacLEOD: And then would certain combina-  
22 tions of penicillin procaine and potassium penicillin be  
23 considered standard?

24 PROF. SUMMERS: Yes.

25 MR. MacLEOD: Apart from that you have  
26 combinations which are not standard?

27 PROF. SUMMERS: That is right.

28 MR. MacLEOD: Now, can you fit standard  
29 combinations into your formulary fairly easily?

30 PROF. SUMMERS: Yes.





1 MR. MacLEOD: Is it more difficult with the  
2 special combinations?

3 PROF. SUMMERS: I can tell you only of my  
4 own formulary, and how we handle this situation.

5 MR. MacLEOD: Yes.

6 PROF. SUMMERS: We list the single drugs.  
7 For example, we list the drug codeine. Under codeine are  
8 listed all of the preparations which we have in stock  
9 which contain the drug codeine, and the actual additional  
10 ingredient, for example, A.P.C. with codeine would actually  
11 be spelled out as to the individual drugs that were  
12 contained in the preparation.

13 MR. MacLEOD: Yes, I see. Another point,  
14 I think you said that certain small firms would not be  
15 known to you so that you would not be in a position to  
16 evaluate their products?

17 PROF. SUMMERS: This may well be.

18 MR. MacLEOD: Does your hospital in fact  
19 use the products of some small firms and small manufacturers?

20 PROF. SUMMERS: This is a difficult question  
21 to answer because I don't know who you mean by "small  
22 manufacturers".

23 MR. MacLEOD: Does your company use the  
24 products of Nordic?

25 PROF. SUMMERS: Yes.

26 MR. MacLEOD: I mean your hospital.

27 PROF. SUMMERS: Yes, indeed.

28 MR. MacLEOD: And finds them quite reliable?

29 PROF. SUMMERS: Yes.

30 MR. MacLEOD: In considering that as a small



1 firm, are there others in the same category?

2 PROF. SUMMERS: Yes. These are largely  
3 specialty firms; firms who specialize in a very narrow  
4 range of products requiring people of a high degree of  
5 specific technical and professional skills such as Nordic  
6 in their extraction of glandular products.

7 MR. MacLEOD: Within that field their  
8 products are quite as good as anybody else's?

9 MR. COOK: I wonder if the witness should  
10 be required to evaluate.

11 PROF. SUMMERS: Can I say this ---

12 THE CHAIRMAN: Perhaps the question should  
13 be not as good, but is it satisfactory to you.

14 PROF. SUMMERS: The answer is yes, we use  
15 Nordic products and they appear to be satisfactory.

16 MR. MacLEOD: Let me put it to you this way:  
17 In your opinion does the size of the supplying firm have  
18 any particular significance in relation to the quality of  
19 its products?

20 PROF. SUMMERS: No, sir. I believe that  
21 the thing that does relate, as Dr. Morrell stated, this is  
22 our guide line, sir.

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I/MR/dpw

1 MR. MACLEOD: In your experience is Dr.  
2 Morrell's statement more applicable to large firms than  
3 to small ones?

4 PROF. SUMMERS: Not necessarily so.

5 MR. MACLEOD: On the point of tenders which  
6 was discussed at some length, you stated, I think, that  
7 there were less than 25 products for which your hospital  
8 called tenders?

9 PROF. SUMMERS: Approximately.

10 MR. MACLEOD: As I understood you, those  
11 would be products which you require in fairly large quanti-  
12 ties?

13 PROF. SUMMERS: Yes, that is right. Yes sir.

14 MR. MACLEOD: Can you give any estimate at  
15 all of the relationship between your purchases of those  
16 particular products and your total expenditures for drugs?

17 PROF. SUMMERS: Approximately - I shouldn't  
18 even guess. I am sorry. It would be approximately 20%.  
19 The reason I say this is that antibiotics constitute 25%  
20 of our dollar volume usage and many of the products for  
21 which we tender are antibiotics.

22 MR. MACLEOD: Now you have used also a  
23 figure I think of 7776 as being mentioned in a compendium.  
24 Is that Dean Hughes' compendium?

25 PROF. SUMMERS: Yes.

26 MR. MACLEOD: Were your figures taken from  
27 page 43 of the brief that is coming next?

28 PROF. SUMMERS: No sir.

29 MR. MACLEOD: But in any event your figures  
30 are intended to represent total number of pharmaceutical



1 specialties listed in Dean Hughes' book?

2 PROF. SUMMERS: That is right sir.

3 MR. MACLEOD: Do you know how many of those  
4 specialties you would actually use in the hospital?

5 PROF. SUMMERS: No, I haven't - no, I don't  
6 know sir. I couldn't do this without a detailed examina-  
7 tion. I have not done this sir.

8 MR. MACLEOD: There would certainly be some  
9 firms, at least, of which you have no personal knowledge and  
10 from whom you do not order your products, in line with the  
11 reasons which have already been discussed?

12 PROF. SUMMERS: Yes, and there is another  
13 very good reason and this is because particular products  
14 are not used in hospitals. This may be a reason for not  
15 ordering from a specific firm.

16 MR. MACLEOD: That is, the products of cer-  
17 tain firms or certain products of certain firms would move  
18 into the retail drug trade rather than the hospitals?

19 PROF. SUMMERS: That is right, and vice versa  
20 too, of course.

21 MR. MACLEOD: There are certain products  
22 that you use that retail druggists would not normally  
23 sell?

24 PROF. SUMMERS: Absolutely. The whole field  
25 of anaesthetic agents; intravenous fluids, injectable  
26 antibiotics, the whole list of injectable preparations do  
27 form a very significant part of the hospital pharmacist's  
28 inventory, are not sold to retail outlets.

29 THE CHAIRMAN: Could you tell us at the  
30 present time approximately how many drug products would



1 you have in your own formulary?

2 PROF. SUMMERS: In our own formulary or in  
3 our hospital sir?

4 THE CHAIRMAN: I thought the ones that were  
5 in your formulary would be the ones you would be ordering.

6 PROF. SUMMERS: Not necessarily sir because  
7 a formulary is not an exclusive listing.

8 THE CHAIRMAN: Perhaps the question should  
9 be approximately how many do you ordinarily carry in your  
10 hospital?

11 PROF. SUMMERS: We have approximately some  
12 4,000 drugs, chemicals and diagnostic agents in our inven-  
13 tory at the present time.

14 MR. MACLEOD: Just touching on prices, do  
15 you buy from the manufacturer wherever it is possible to  
16 and convenient to do so?

17 PROF. SUMMERS: Yes.

18 MR. MACLEOD: And do you find, generally  
19 speaking, that you get the best price when you buy direct  
20 from the manufacturer?

21 PROF. SUMMERS: Not always.

22 MR. MACLEOD: Would you give me an illustra-  
23 tion where this would not be true?

24 MR. COOK: Is he asking about a specific  
25 manufacturer and a specific product?

26 THE CHAIRMAN: He is asking for any instance  
27 in which it has not been true of getting a better price  
28 from the manufacturer than somebody else?

29 PROF. SUMMERS: It actually did. It was -  
30 I am at a loss how to explain this, but it came from





1 subtraction of sales tax from the order.

2                   The manufacturer subtracted approximately  
3  $9\frac{1}{2}\%$  from the normal listing of the drug, whereas the whole-  
4 saler, I think to make it easier, subtracted a straight  
5 10% and we were able to purchase the drug cheaper from the  
6 wholesaler than we were from the manufacturer.

7                   You must also understand there are a number  
8 of drugs which are sold only through wholesalers.

9                   MR. MACLEOD: Are you able to purchase the  
10 products of Eli Lilly direct from the manufacturer?

11                   PROF. SUMMERS: No. They are supplied  
12 through the wholesaler.

13                   MR. MACLEOD: You must place your orders  
14 through a wholesaler?

15                   PROF. SUMMERS: Yes.

16                   MR. MACLEOD: Going back, before we leave it,  
17 to this instance you spoke of a moment ago of a lower price  
18 happening from the computation of sales tax, is that an  
19 isolated instance?

20                   PROF. SUMMERS: Yes, it is. It is not  
21 general.

22                   MR. MACLEOD: Is it true that, generally  
23 speaking, you get a better price from the manufacturer?

24                   PROF. SUMMERS: Oh yes.

25                   MR. MACLEOD: You also said, I think, that  
26 traditionally in respect to certain products special  
27 prices are allowed the hospital by manufacturers?

28                   PROF. SUMMERS: Yes.

29                   MR. MACLEOD: Does that apply to a fairly  
30 wide range of products?



1 PROF. SUMMERS: No.

2 MR. MACLEOD: Would that apply equally to  
3 those products that are used chiefly in hospitals?

4 PROF. SUMMERS: No.

5 MR. MACLEOD: Is there any general way you  
6 can categorize the products to which it does apply?

7 PROF. SUMMERS: Yes. They are generally  
8 applied to products which the patient may purchase without  
9 a prescription when he is discharged from the hospital.  
10 May I use an example?

11 MR. MACLEOD: Yes, certainly.

12 PROF. SUMMERS: Magnolax, for example, which is a  
13 commonly used laxative is normally put up in a very special  
14 hospital pack. The special sized bottle is available only  
15 to hospitals. This is then issued to the patients for use  
16 in their hospital stay.

17 Now we can purchase this product in this  
18 pack at a lower cost to us than if we were to purchase in  
19 the gallon quantities by which we normally purchase some  
20 items, but I must make it clear that this special pack is  
21 not available to the retail pharmacists. It is a special  
22 hospital pack.

23 MR. MACLEOD: Are you able to offer any  
24 opinion as to why this practice is followed?

25 PROF. SUMMERS: I don't think I am competent  
26 to judge that sir.

27 MR. MACLEOD: Do you know if in fact in  
28 practice the patient sees the manufacturer's package when  
29 you get it in these hospital packages?

30 PROF. SUMMERS: I can tell you only what



1 happens in my hospital and the answer is ~~no~~.

2 MR. MACLEOD: He does not?

3 PROF. SUMMERS: No.

4 MR. MACLEOD: Are you able to get these  
5 special hospital prices, which you told us about, when  
6 you purchase through wholesalers?

7 PROF. SUMMERS: Again sir I wouldn't like  
8 to answer that because I cannot think of any specific  
9 instance when it has happened and yet - let's just leave  
10 it at that. I don't know.

11 THE CHAIRMAN: Does that mean that in a  
12 great majority of cases it does not happen?

13 PROF. SUMMERS: It does not happen sir, yes,  
14 in the majority of cases.

15 MR. MACLEOD: I want to go back to what we  
16 were discussing first, and let's take your statement on  
17 page 10 at the very bottom of the page, under 2 you state  
18 that the present system of naming drugs has failed. In  
19 what respect and just how has it failed?

20 PROF. SUMMERS: I think it has failed to  
21 give guidance to the physician in identifying the chemical  
22 groupings to which the drug belongs.

23 MR. MACLEOD: When you speak of the present  
24 system of naming drugs are you speaking of the present  
25 system of giving brand names to drugs?

26 PROF. SUMMERS: I am speaking of both  
27 systems, the whole gamut of drug nomenclature. The reason  
28 I say this is because of a series of papers which appeared  
29 in various medical journals about six months ago.

30 MR. MACLEOD: In respect to generic names



1 then just what is your criticism?

2                   PROF. SUMMERS: Well the general criticism  
3 is that the generic names are not easy to remember  
4 generally. They do not indicate the chemical group from  
5 which the drug - to which the drug belongs, except in  
6 certain cases. May I use an example? One of the nicest  
7 examples of a group of drugs which is well-named generi-  
8 cally are the tetracycline group of drugs. We have tetra-  
9 cycline itself, tetracycline hydrochloride. Then we have  
10 oxytetracycline hydrochloride. We have chlortetracycline  
11 and then we have demethyl chlortetracycline and as each  
12 one has come out it has been a tetracycline and therefore  
13 we know that they are all of the same chemical genus and  
14 from a therapeutic point of view they should behave in a  
15 similar pattern. This, of course, we know does not neces-  
16 sarily follow.

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1                    PROF. SUMMERS: It is simply because it is  
2 of a certain pattern that we will obtain the same thera-  
3 peutic response, we would expect a similar therapeutic  
4 response much more frequently when the drugs follow a  
5 pattern than when they don't.

6                    MR. MacLEOD: What is your opinion about  
7 the generic names used in connection with the cortisone  
8 group?

9                    PROF. SUMMERS: These have come along. We  
10 have cortisone, hydrocortisone, prednisone and prednisolone.  
11 After that we become a bit unstuck. We have triamcinolone.  
12 There is nothing in triamcinolone that normally you might  
13 refer it to the drugs from which it derives, the  
14 prednisone and the prednisolones or the basic steroids  
15 themselves.

16                   MR. MacLEOD: What about the tranquilizers?

17                   PROF. SUMMERS: The tranquilizers as a rule  
18 are not badly named. We do have some, for example the  
19 drug meprobamate and carisoprodal. They are second cousins,  
20 but nothing in their terminology would tell us this.

21                   MR. MacLEOD: Could you give us some examples  
22 of generic names you think are extremely bad?

23                   PROF. SUMMERS: That was, meprobamate and  
24 carisoprodal have nothing in their generic name that would  
25 indicate they are so related. I might also say we are  
26 now getting into a highly technical area and without a  
27 very thorough study of it I wouldn't be prepared to go  
28 further.

29                   MR. MacLEOD: As a hospital pharmacist what  
30 is your opinion as to the use of brand names along with the





1 generic or official name, is it desirable in marketing the  
2 product or not?

3 PROF. SUMMERS: From whose point of view,  
4 from my point of view?

5 MR. MacLEOD: Yes.

6 PROF. SUMMERS: I have no objection to it.

7 MR. MacLEOD: You have no objection.

8 PROF. SUMMERS: I have no objection. I  
9 think it serves a useful purpose.

10 MR. MacLEOD: In preparing your formulary,  
11 you show generic names with a cross-reference?

12 PROF. SUMMERS: With a cross-reference, yes.

13 MR. MacLEOD: I think you already indicated  
14 in some cases it might be a source of confusion. Have you?

15 PROF. SUMMERS: Yes, I have, sir.

16 MR. MacLEOD: Will you agree with the comment  
17 in the green book or a statement of a doctor that is quoted  
18 in the green book where he says brand name, use of brand  
19 names has been carried to such an extent specialists in the  
20 same field may be talking about the same drug but not  
21 realize it?

22 PROF. SUMMERS: I have no competent knowledge  
23 of the drug knowledge of specialists. It may well be.  
24 I have no knowledge of it.

25 MR. MacLEOD: Have you any knowledge of  
26 confusion arising within your own experience by the use of  
27 brand names?

28 PROF. SUMMERS: Yes, but I also have just  
29 the same examples of confusion arising from generic names.

30 MR. MacLEOD: The same type of confusion?



1 PROF. SUMMERS: The same type of confusion.

2 MR. MacLEOD: Would you.....

3 PROF. SUMMERS: One drug being mistaken for  
4 another because of similarity of sound or, at least, writing.

5 MR. MacLEOD: That is of the pharmacist  
6 interpreting the prescription?

7 PROF. SUMMERS: Yes.

8 THE CHAIRMAN: Interpreting or deciphering?

9 MR. CARIGNAN: You said brand names were  
10 fulfilling a useful function?

11 PROF. SUMMERS: Yes sir.

12 MR. CARIGNAN: Could you be more specific  
13 about that function?

14 PROF. SUMMERS: I think it fulfils a very  
15 useful function to the manufacturer in allowing specific  
16 products to be identified. I think they are of great use  
17 to him.

18 MR. CARIGNAN: That could be done by having  
19 the name of the manufacturer ....

20 PROF. SUMMERS: Absolutely.

21 MR. CARIGNAN: Added?

22 PROF. SUMMERS: This could be fulfilled by  
23 other means, yes.

24 MR. MacLEOD: Now, in respect of hospitals,  
25 at least, since they do most of their purchasing from the  
26 manufacturer they know whose products they are using?

27 PROF. SUMMERS: Yes.

28 MR. MacLEOD: So that in that respect, at  
29 least, the brand name doesn't serve any particular function?

30 PROF. SUMMERS: Oh, no.



1 MR. MacLEOD: Whatever it may do in the  
2 retail trade?

3 THE CHAIRMAN: The answer is no?

4 PROF. SUMMERS: The answer is no, sir.

5 MR. MacLEOD: Have you any knowledge of  
6 hospital purchasing practices in the United States?

7 PROF. SUMMERS: No.

8 MR. MacLEOD: When you purchase wholesale,  
9 do you purchase tax exempt?

10 PROF. SUMMERS: Yes, sir.

11 MR. MacLEOD: Any taxes that may have been  
12 paid are the worry of the wholesaler rather than your  
13 hospital. Your brief seems to suggest hospital pharmacists  
14 may need to be more highly trained than those employed in  
15 the retail trade; is that correct?

16 PROF. SUMMERS: I don't think that is  
17 correct. We specifically stated the background required  
18 for hospital pharmacists. We make no mention of retail  
19 pharmacists whatever. However, I think we must realize  
20 this, the major difference between a hospital pharmacist  
21 and a retail pharmacist is administration. The difference  
22 is not professionally.

23 MR. MacLEOD: Yes. I was wondering if you  
24 could express any opinion as to whether you call upon the  
25 services of the manufacturer to as great an extent as the  
26 retailer, that is the detailmen's knowledge and so on?

27 PROF. SUMMERS: The detailmen do call on us  
28 and through us make appointments with doctors on our  
29 medical staff who have offices in the hospital. They  
30 acquaint us with new products that come out as they come



1 out. I would say perhaps we use their services as much or  
2 even a little more than the retail pharmacist does because  
3 of the greater scope of pharmaceuticals carried in the  
4 hospital. We depend on them.

5 MR. MacLEOD: What I am trying to get your  
6 opinion on is, it has been suggested or it is inferred or  
7 some suggestions have been made the manufacturer can sell  
8 more cheaply to the hospital, sell at lower prices to the  
9 hospital because the hospital doesn't draw on the services  
10 to the same extent as the retailer does?

11 PROF. SUMMERS: I wouldn't agree with that.  
12 I think he draws on the services to a much higher degree.

13 MR. MacLEOD: In your work do you teach  
14 either medical students or pharmacists?

15 PROF. SUMMERS: Yes sir.

16 MR. MacLEOD: What do you teach in the way  
17 of names? Do you suggest the generic name, trade name or  
18 what?

19 PROF. SUMMERS: This is a good question. It  
20 is very difficult to teach names. As well as medical  
21 students and pharmacists I teach to a group of nurses.  
22 These are the people who actually use, administer the  
23 drugs to the patient, therefore you must teach the non-  
24 proprietary names and the trade names and make sure they  
25 know the name that is currently used in the hospital by  
26 the medical staff.

27 MR. MacLEOD: That name would be generic?

28 PROF. SUMMERS: It may be. It may not be.  
29 There is the drug pethidine which is sold under the name  
30 of demerol and another trade name, also meperidine. We



1 use the brand Demerol therefore we must make sure our  
2 people remember the name Demerol.

3 MR. MacLEOD: What is Demerol?

4 PROF. SUMMERS: Pethidine Hydrochloride and  
5 Meperidine. It is an analgesic.

6 MR. MacLEOD: The first name is the brand  
7 name?

8 PROF. SUMMERS: Demerol is Winthrop's brand  
9 of pethidine hydrochloride.

10 MR. MacLEOD: In this particular instance  
11 you are using the brand name, really, in the generic sense  
12 because you are using it meaning the product, similar  
13 product of other companies?

14 PROF. SUMMERS: Oh no. If I use Demerol  
15 it means only it is Winthrop's brand of pethidine hydro-  
2 16 chloride.

17 MR. MacLEOD: Perhaps I didn't understand  
18 you. I thought you used Demerol?

19 PROF. SUMMERS: You must make sure that the  
20 students use it. You can't go on gaily and teach pharma-  
21 cology and not at some point tell them the brand of pethidine  
22 hydrochloride is Demerol and when you go to your order  
23 sheet you are not going to find it. You are going to  
24 find Demerol. When you find Demerol that is what I am  
25 talking about. You must make sure these classes understand  
26 this. In the other drugs the name probably will be the  
27 non-proprietary name that is used.

28 MR. MacLEOD: To your knowledge is there  
29 another brand of this particular product you are speaking  
30 about on the market?





1                   PROF. SUMMERS: Yes, there is.

2                   MR. MacLEOD: Do you teach the use of it?

3                   PROF. SUMMERS: No, because I can't remember  
4 it. I can't remember it. I don't know it, so I don't teach  
5 it. There is another name of this drug, certainly.

6                   MR. MacLEOD: There is another name used  
7 by another manufacturer?

8                   PROF. SUMMERS: Yes, it is a trade name.  
9 As I say, I am sorry it escapes me. I can't remember it.

10                  MR. MacLEOD: In this particular instance  
11 the manufacturer who is implanted -- the students taught  
12 by you will use his particular name products regardless of  
13 what other brand names may be on the market.

14                  PROF. SUMMERS: No, I wouldn't say that at  
15 all.

16                  MR. MacLEOD: You only teach him one place  
17 to get it?

18                  PROF. SUMMERS: No, I don't.

19                  MR. MacLEOD: Perhaps I misunderstood.

20                  PROF. SUMMERS: I said right now I cannot  
21 recall what the other name is. You didn't ask if I mentioned  
22 it. We would mention it is also available from such and  
23 such a firm, another series of firms.

24                  MR. MacLEOD: I thought you said that you  
25 didn't teach it because you couldn't remember it.

26                  PROF. SUMMERS: I am sorry, I can't recall  
27 it right now.

28                  MR. MacLEOD: In your teaching you would  
29 point out there is Brand A, Brand B, Brand C, Brand D.

30                  PROF. SUMMERS: Absolutely. For example,



1 tetracycline hydrochloride, we would say there are a number  
2 of brand names and we would have to use a cross-reference  
3 with all the available brand names. That we would do.

4 MR. MacLEOD: I am sorry, I misunderstood  
5 what you said. Just to clear up what you said on intern-  
6 ship. Is that an additional internship you require than  
7 the admission to practise pharmacy within the province?

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1                   PROF. SUMMERS: It well may be. The intern-  
2 ship in hospital pharmacy is a period of close to graduate  
3 training, in that it is training after graduation spent  
4 in a hospital on an organized program of training, under  
5 the supervision of a hospital pharmacist. It is intended  
6 to train graduate pharmacists in the specific administra-  
7 tive and technical skills associated primarily with hospi-  
8 tal pharmacy.

9                   MR. MACLEOD: I think you said something in  
10 answer to a question of the Chairman in connection with  
11 the use of the products listed in the formulary and the  
12 use of products outside the formulary. You said that  
13 doctors within the hospital were required in circumstances  
14 you outlined to use the products listed in the formulary,  
15 is that correct?

16                  PROF. SUMMERS: Not entirely, in this regard,  
17 the formulary is not an exclusive list of the only drugs  
18 available in the hospital. We carry a much wider selec-  
19 tion of drugs than those listed in the formulary.

20                  MR. MACLEOD: You mentioned something about  
21 bringing evidence to the Committee, if you have a product  
22 or something like that. What was that in connection with?

23                  PROF. SUMMERS: Let us take an example. If  
24 we happen to be using Lederle's brand of tetracycline  
25 hydrochloride which normally is Achromycin in the hospital,  
26 and one of the physicians says, "I want Steclin -" - which  
27 is Squibb's brand of tetracycline hydrochloride - "-brought  
28 into the hospital for my specific use" - he would be  
29 required to have evidence that Squibb's brand of tetra-  
30 cycline hydrochloride produces superior clinical response



1 and/or less side-effects than Lederle's brand of tetra-  
2 cycline hydrochloride.

3 MR. MACLEOD: I think you said that this  
4 had not given you much difficulty.

5 PROF. SUMMERS: It has never given me any  
6 difficulty, in that we have had no one insist on one  
7 specific brand. Again I must qualify this because it  
8 is quite a complex field.

9 On the other hand let us take the drug Thy-  
10 roid which is manufactured by many companies. Our Commit-  
11 tee has said that you will purchase, or it has been found  
12 through clinical observation that Thyroid purchased from  
13 say one or two firms appears to produce a consistent res-  
14 ponse, whereas some of the others may not, and therefore  
15 they say, "You will buy either from manufacturer 1, 2 or  
16 3, but as long as you confine your purchase to those  
17 groups, this is all right".

18 MR. MACLEOD: Does that mean in this instance  
19 that your hospital would stock 1, 2 and 3?

20 PROF. SUMMERS: No, 1, 2 or 3.

21 MR. MACLEOD: You would stock 1, 2 or 3?

22 PROF. SUMMERS: Yes.

23 MR. MACLEOD: I have just one other question,  
24 and I may have some difficulty in framing it. As I under-  
25 stand the evidence of Dr. Dixon, he said that if brand  
26 names were not successful, the market would throw them out  
27 and some other method would be found. Does the fact that  
28 brand names are successful in a commercial sense mean that  
29 they are useful to the hospital or is there any relation-  
30 ship between the two at all?



1 PROF. SUMMERS: I think there is no relation-  
2 ship there at all.

3 MR. MACLEOD: And conceivably then brand  
4 names might be successful in a commercial sense but not  
5 assist in any way the hospital's operation, in fact they  
6 might be a detriment?

7 PROF. SUMMERS: They certainly would not  
8 assist.

9 MR. MACLEOD: So that these two facets have  
10 no relationship to each other?

11 PROF. SUMMERS: No sir, except, let us  
12 clarify it, in those cases where drugs are only available  
13 under a brand name such as in certain combinations. Here  
14 they would assist.

15 MR. MACLEOD: They would assist.

16 PROF. SUMMERS: Let us take a drug combina-  
17 tion which contains a number of individual items, let us  
18 say 8 items. This is much more easily described by a  
19 single brand name than having to list each of the 8 indi-  
20 vidual items, and therefore in this respect a trade name  
21 does have a useful purpose in the hospital.

22 MR. MACLEOD: In those particular circum-  
23 stances?

24 PROF. SUMMERS: Yes, but we must qualify  
25 them.

26 MR. MACLEOD: One other point. In your  
27 hospital is there much actual compounding done on the  
28 premises?

29 PROF. SUMMERS: We do a considerable amount  
30 of bulk compounding, yes. We compound injections and a





1 wide variety of preparations.

2 MR. MACLEOD: What do you mean "bulk compoun-  
3 ding"?

4 PROF. SUMMERS: Compounding in large quanti-  
5 ties. I mean in mouthwash we make 30 gallons at a time  
6 instead of 8 ounces.

7 MR. MACLEOD: What I was trying to get at  
8 is, it was suggested that somewhere between 85 and 90% of  
9 prescriptions sold in drugstores are materials completely  
10 prepared by the manufacturer. In the remaining percentages  
11 the druggist actually goes into the dispensary and takes  
12 down different ingredients and compounds them.

13 Can you give us any idea of the percentage  
14 of prescriptions in your hospital which would be compounded  
15 in that sense?

16 PROF. SUMMERS: I think there is a difference  
17 in the hospital which perhaps you don't understand. This  
18 is that much of the material manufacturers are compounding  
19 for the pharmacists is not used to fill a specific pres-  
20 cription, but goes up to the ward to be used as such. I  
21 think, for instance, of such things as back lotion, mouth-  
22 wash and antiseptic solutions and irrigating solutions  
23 which are not for injection, and also a large variety of  
24 injections. These materials are placed on the wards for  
25 the use of the staff and therefore you get a wide compoun-  
26 ding field in hospitals which normally does not fall to  
27 the lot of the retail manufacturer.

28 MR. MACLEOD: Are there certain dosage forms  
29 that you cannot buy from the manufacturer directly?

30 PROF. SUMMERS: Yes.



1 MR. MACLEOD: Which still must be mixed by  
2 the pharmacist in the hospital?

3 PROF. SUMMERS: Yes. I can give you some  
4 idea of the degree to which this goes on. We employ a  
5 pharmacist full-time and a non-professional staff member  
6 full-time to do nothing but compounding, and 75 to 80% of  
7 the products which they compound are not available on the  
8 market.

9 MR. MACLEOD: Do these compounds bear an  
10 important relationship to your overall use of drugs? I  
11 am thinking of the 85 to 90% in the case of retail pharma-  
12 cists.

13 PROF. SUMMERS: That is a difficult question  
14 to answer. I could not estimate the proportion either  
15 individually or volume-wise or dollar volume-wise, because  
16 you cannot attach a dollar volume to these things, because  
17 they have no comparable cases outside of the hospital.

18 MR. MACLEOD: We will just leave it as far  
19 as that goes. Those are all the questions I have.

20 THE CHAIRMAN: Mr. Summers, this point  
21 occurred to me as you were going along. I presume the  
22 cost of drugs is a fairly important item in the total  
23 expenditures of the hospital?

24 PROF. SUMMERS: Sir, in our hospital, the  
25 cost of drugs five years ago represented about 3.2% of  
26 the total hospital budget. In five years' time we have  
27 reviewed it and it now represents approximately 3.4% of  
28 the total hospital budget.

29 THE CHAIRMAN: You mean it has become less  
30 important?



1                   PROF. SUMMERS: It has not become less impor-  
2 tant, but it has increased about two-tenths of one percent.  
3 We have some figures here on a list. What you find is  
4 there is no one individual drug which we have started to  
5 use that has increased in price, yet on the other hand,  
6 we can show you some very significant examples of drugs  
7 which have decreased markedly in price as they have become  
8 more readily available. Yet the patient-day cost of drugs  
9 continues to rise.

10                   There are reasons for this. First of all,  
11 it varies with the type of work which is done in the hos-  
12 pital. Those hospitals which do large amounts of surgery  
13 find their drug costs are much higher. If you have a very  
14 rapid turnover of patients, your drug costs are higher  
15 because drug costs are higher in the acute phases of illness,  
16 and if you keep your people for only a short period of  
17 time, you only have an acute phase, and if on the one hand  
18 you are making better use of your facilities, you are also  
19 driving your drug costs up.

20                   Drug costs in treating various categories of  
21 patients vary from \$2 to 30 cents a patient-day, and inci-  
22 dentally, the cost of medicating completely a psychiatric  
23 patient which uses most of the tranquilizers is only 30  
24 cents a patient, but the cost per patient-day for surgery  
25 is from \$2.50 to \$2 per patient-day.

26                   THE CHAIRMAN: You mentioned the cost per  
27 patient-day had been increased while the cost of indivi-  
28 dual drugs on an average has been going down.

29                   PROF. SUMMERS: Correct.

30                   THE CHAIRMAN: That is due to the fact that



1 there are more drugs being used per patient, or being used  
2 for many more patients.

3           PROF. SUMMERS: Both factors are involved,  
4 and also the type of work you are doing. Because of the  
5 drugs available, you may carry out certain surgical and  
6 medical procedures which you could not do before, because  
7 the patient just went home and died. Nowadays we can  
8 treat him because those drugs are available. The factors  
9 contributing to our costs are in fields which have very  
10 little relationship to retail pharmacies, and I think  
11 particularly in the field of anaesthetic agents. The  
12 single most expensive agent which we have in the hospital  
13 is anaesthetics, and also another large-volume drug is  
14 intravenous fluids which do not enter into the retail field  
15 at all.

16           THE CHAIRMAN: I was glad to ask that ques-  
17 tion also, because I happened to be talking to the admini-  
18 strator of a large hospital recently. He told me their  
19 costs had been going up substantially, and they now ran  
20 about \$1,000 a day. I don't know how many beds there are  
21 in that hospital, but I think it would not be more than an  
22 average of a dollar per patient per day.

23           PROF. SUMMERS: If it is only costing him  
24 a dollar a patient a day in a large hospital he is doing  
25 very well.

26           THE CHAIRMAN: Yours is more than that?

27           PROF. SUMMERS: Slightly higher.

28           THE CHAIRMAN: We have been impressed by the  
29 fact that the use of drugs has increased substantially over  
30 the last number of years both in hospital and out of hospital.



1 PROF. SUMMERS: Yes sir.

2 THE CHAIRMAN: And partly for that reason,  
3 together with the fact that certain new drugs, the wonder  
4 drugs, are generally much more expensive to obtain than  
5 the older type of drugs - those were the questions that  
6 led to the setting up of this inquiry. The proportionate  
7 cost of drugs has increased very, very little indeed.

8 PROF. SUMMERS: That is right, the general  
9 cost of hospitalization has increased.

10 THE CHAIRMAN: Yes. It has increased a  
11 great deal. The per diem rate to the patient seems to  
12 indicate the general cost has gone up. Are there any  
13 further questions?

14 Thank you, Dr. Summers; we appreciate your  
15 giving us all this information. We will adjourn till 2.15.

16  
17 --- Luncheon adjournment.  
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1 ---On resuming at 2.15 p.m.

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3 THE CHAIRMAN: Mr. Cook, will you be  
4 presenting or leading the witnesses?

5 MR. COOK: Only introducing, Mr. Chairman.  
6 If it please the Board, I have already indicated whom I  
7 represent, the Canadian Pharmaceutical Association, and  
8 this is an association of retailers as distinct from my  
9 friend Mr. Hume's clients who have already appeared, the  
10 Pharmaceutical Manufacturers Association.

11 THE CHAIRMAN: You do have some wholesalers,  
12 do you not, as members?

13 MR. COOK: Mr. Turnbull will explain that  
14 when he goes into the organization.

15 THE CHAIRMAN: All right.

16 MR. COOK : I would like to say "no", but  
17 there are certain qualifications.

18 THE CHAIRMAN: I thought there were some.

19 MR. COOK: Perhaps I should mention to the  
20 Commission before going further that in attendance with me to-  
21 day are Mr. D. R. Mitchell, Sudbury, who is president of  
22 the Association, and Mr. D. F. McKeague of Calgary, who is  
23 the immediate past-president.

24 Dr. A. W. Matthews -- if you have the list  
25 there it will save the Commission writing them down --  
26 Dr. Matthews is the Dean of the Faculty of Pharmacy of  
27 U.B.C. And Mr. J. K. Lawton, who is the second vice-  
28 president of the Association, and comes from Halifax, Nova  
29 Scotia. Then there will be from the office of the Associa-  
30 tion, Mr. John Turntull, who is the secretary manager, and



1 his assistant secretary, Mr. T. M. Ross, who is sitting  
2 beside me.

3 Mr. Turnbull, with your permission, sirs,  
4 will present the brief of the Association, and I will ask  
5 him now to come forward if he will. Is my recollection  
6 right, you are not swearing witnesses?

7 THE CHAIRMAN: We did that for a few in  
8 Ottawa because we were requested to do so. As a great  
9 deal of the material we are getting seems to be on informa-  
10 tion or belief or opinion anyway -- we also were of the  
11 opinion we were getting the truth whether they were sworn  
12 or not, and it didn't make any vital difference in the  
13 quality of the evidence.

14 MR. COOK: Perhaps I could say for Mr.  
15 Turnbull, his full name is John Cameron Turnbull.

16 For the purpose of the record, Mr. Turnbull,  
17 you are Secretary Manager of the Canadian Pharmaceutical  
18 Association?

19 MR. TURNBULL: That is correct.

20 MR. COOK: Would you outline to the  
21 Commission your history in terms of the practice of  
22 pharmacy so that they will know your qualifications in  
23 pharmacy?

24 MR. TURNBULL: I am a pharmacist. I obtained  
25 my Bachelor of Science (Pharmacy) degree at the University  
26 of Saskatchewan in 1949. I have been employed in retail  
27 pharmacy in a large dispensing pharmacy.

28 I have apprenticed in both village and  
29 suburban pharmacies. For two years I was supervisor of  
30 pharmaceutical services of the Department of Public Health in



1 Saskatchewan.

2 I spent one year as operations manager of  
3 a wholesale drug house before my appointment as general  
4 manager and secretary-treasurer of the Association in  
5 October 1953.

6 THE CHAIRMAN: So your total experience in  
7 pharmacy is how many years?

8 MR. TURNBULL: I have been with the Associa-  
9 tion, sir, for eight years. I did part of my apprenticeship  
10 before joining the Air Force in 1940, and attended university  
11 following World War II.

12 I worked in a retail pharmacy during my  
13 latter years at the university, and for one year after. I  
14 have been in pharmacy since 1939.

15 MR. COOK: You have held your present appoint-  
16 ment I think since 1953?

17 MR. TURNBULL: That is correct.

18 MR. COOK: With that background, Mr. Turnbull,  
19 you are presenting the Association's brief?

20 MR. TURNBULL: Yes. Mr. Chairman, and  
21 members of the Commission, before opening our presentation  
22 on behalf of the officers and members of the Canadian  
23 Pharmaceutical Association, we wish to commend those under  
24 whose supervision and authorship the Director's statement  
25 was prepared.

26 The statement is comprehensive in its scope.  
27 While we might take issue with certain paragraphs therein,  
28 we are of the opinion that it searches out information of  
29 value concerning most aspects of drug distribution in  
30 Canada.



1 The statement which our Association is  
2 presenting to the Commission is not as brief as we would  
3 like it to be. However, it deals in a comprehensive manner  
4 with many aspects of pharmacy and pharmaceutical practice  
5 in Canada. It is our belief that background information  
6 is essential information required by the Commission in its  
7 current study.

8 Further, while aware of the Commission's  
9 terms of reference, we have been disturbed by the amount  
10 of extraneous material that has appeared in the hearings,  
11 and as a result, in the public press. Therefore we felt  
12 it very necessary, with the information which we are  
13 presenting, to place factual material on the public record.

14  
15 INTRODUCTION

16 In presenting itself before the Restrictive  
17 Trade Practices Commission in the course of its inquiry  
18 relating to the manufacture, distribution and sale of drugs  
19 in Canada, the Canadian Pharmaceutical Association does so  
20 with a deep sense of true obligation to the members of the  
21 profession of Pharmacy which it represents, to the ill  
22 and diseased of our population, to the general public of  
23 our nation and to those who sit in our elected parliaments  
24 and legislatures. More specifically, in presenting  
25 ourselves today to discuss the many areas and problems which  
26 we believe will yield significant information to the  
27 Commission, we hope to fulfil a rightful obligation and duty  
28 to Commissioners who are faced with the task of weighing  
29 the merits of argument and evidence, be it hearsay or factual,  
30 and in so doing, assist them in the making of proper



1 decisions, the significance of which shall have an ever-  
2 lasting effect on both the economy of Canada and on the  
3 health and welfare of Canadian citizens.

4                   The Canadian Pharmaceutical Association  
5 has repeatedly said that it welcomes a sane, comprehensive  
6 investigation related to the manufacture, distribution  
7 and sale of drugs in Canada. The Association is of the  
8 opinion that such a review will provide the public with  
9 proper facts and in doing so, will dispel the element of  
10 distrust which has been created in recent years and which,  
11 if allowed to continue, will seriously affect the proper  
12 utilization of drug therapeutic agents with consequent  
13 adverse results on general health and welfare. Gentlemen,  
14 in this presentation where I refer to the initials  
15 C.Ph.A., this will refer directly to the Canadian  
16 Pharmaceutical Association.

17                   The Canadian Pharmaceutical Association has  
18 studied the material collected by the Director of Investi-  
19 gation and Research, commonly referred to as the 'green  
20 book', and is aware of the proceedings of the Commission's  
21 hearings which were conducted in various cities of Canada  
22 during the months of July and August. The discussions of  
23 this presentation will, in the main, be limited to the  
24 areas of study initiated by our reading of the 'green book'  
25 and the transcripts of those regional hearings. It is the  
26 aim of this presentation to include only constructive  
27 criticism and factual information about the practice of  
28 Pharmacy and the distribution of drugs in Canada, as  
29 such is known to the Association which is representative  
30 of all registered pharmacists and their organizations in





1 Canada.

2                   It is assumed that the Commission if fully  
3 conversant with the proceedings of the hearings which have  
4 been conducted by the Select Committee on Drugs of the  
5 Province of Ontario. It is assumed, also that the Commission  
6 has, in its possession, information arising from the  
7 Advisory Planning Committee on Medical Care of the Province  
8 of Saskatchewan, as well as the results of the joint study  
9 undertaken in Manitoba by the Government of that Province  
10 with the Manitoba Pharmaceutical Association, pertaining  
11 to the rendering of pharmaceutical services to the  
12 pensioners and indigents therein. The statements made in  
13 this brief may, to some extent, be repetitious of the  
14 information presented before these other important bodies,  
15 but an attempt will be made to not belabour them in our  
16 discussions.

17                   With this brief will be submitted certain  
18 exhibits by way of illustration of statements. Appendices  
19 will also be attached which will serve to review, in a more  
20 detailed manner, matters dealt with in summary form.

21 ORIENTATION

22                   The Canadian Pharmaceutical Association, Inc.,  
23 founded in 1907 and incorporated by Charter in 1923, is a  
24 federation of the provincial statutory Pharmacy organizations  
25 which are charged with the responsibility of the administra-  
26 tion of provincial Pharmacy Acts. As originally written by  
27 its founders in 1907, and as stated on its Charter, the  
28 objects of the Association are: (a) to advance the science  
29 and practice of Pharmacy; (b) to promote and protect the  
30 commercial interests of its members; (c) to promote the



1 mutual interests of its associations, societies and  
2 colleges and their members; and (d) to bring together  
3 their members in professional commercial and social  
4 gatherings. Ten provincial statutory Pharmacy organizations  
5 constitute the constituent-membership of the Association.  
6 All individual pharmacists, by virtue of their registra-  
7 tion with one or more of these constituent organizations,  
8 are individual members of the Canadian Pharmaceutical  
9 Association.

10 MR. COOK: Before you go any further, would  
11 you deal with the Chairman's question as to whether you  
12 embrace any wholesalers? I think this is a convenient  
13 point to do it.

14 MR. TURNBULL: Mr. Cook, I believe if I can  
15 deal with that at this point, it is dealt with in a more  
16 extensive break-down, the character of the Association.  
17 I have quoted numbers I believe at page 17 of our presenta-  
18 tion, "Manpower". It may be advantageous to present them  
19 now.

20 The records of the Canadian Pharmaceutical  
21 Association as of June 30, 1961, indicate a membership total  
22 of 8940 pharmacists, 63 of whom reside in countries other  
23 than Canada, and the balance, by vocation, as follows:

24 Owners, managers or partners of retail	
25 pharmacies	- 5357
26 Pharmacist-employees in retail pharmacies	- 2620
27 Hospital pharmacists	- 392
28 Pharmacists employed in industry	- 271
29 Pharmacists in government and armed forces	- 39
30 Professors, graduate students	- 51



1 Miscellaneous categories

- 147.

2 Those would be registered pharmacists who are not practising  
3 pharmacy. I might add the foregoing, regrettably, cannot  
4 be considered as a completely accurate breakdown of our  
5 membership listing according to pharmaceutical vocation or  
6 endeavour, as the Association's flow of information is not  
7 always completely up-to-date in the face of movements within  
8 the profession and the different methods of record keeping  
9 on the part of the provincial statutory pharmacy organiza-  
10 tions from which the Association receives its information.  
11 A further breakdown is presented in Table 1.

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1 MR. COOK: Can we understand then that the  
2 wholesalers, as such, are not members of the Association?

3 MR. TURNBULL: Individual pharmacists  
4 employed in wholesale are members of the Association  
5 provided they are registered with a Provincial Statutory  
6 Organization.

7 MR. COOK: That is by reason of their regis-  
8 tration, not by reason of the fact that they are whole-  
9 salers?

10 MR. TURNBULL: That is correct.

11 THE CHAIRMAN: You do not have any corporate  
12 members?

13 MR. TURNBULL: We have no corporate members.

14 THE CHAIRMAN: On that same basis, as we  
15 speak with regard to wholesalers, I suppose a pharmacist  
16 who is employed by a manufacturer might also be a member,  
17 might he?

18 MR. TURNBULL: That is correct.

19 THE CHAIRMAN: Would that be the only connec-  
20 tion with manufacturers that you have?

21 MR. TURNBULL: Yes.

22 MR. COOK: I interrupted you when you  
23 finished the first paragraph on page 3, Mr. Turnbull.

24 MR. TURNBULL: It is pointed out to the  
25 Commission that recently the College of Pharmacists of the  
26 Province of Quebec gave notice of withdrawing as a consti-  
27 tuent member of the Association. Because the constitution  
28 of the Association requires twelve months' notice of with-  
29 drawal, Quebec pharmacists are technically members until  
30 the close of the Association's current fiscal year, June 30,



1 1962. Notwithstanding this, the College of Pharmacists of  
2 the Province of Quebec considers itself not to be affiliated  
3 with the Canadian Pharmaceutical Association at the present  
4 time and, therefore, may not wish to be a party to this  
5 submission before the Commission.

6               The Canadian Pharmaceutical Association is  
7 governed by a council composed of four representatives of  
8 each provincial statutory pharmacy organization. In each  
9 case, two of these representatives are pharmacists  
10 appointed on the recommendation of the commercial pharmacy  
11 organization in that province. In addition, one represen-  
12 tative from each of the following national organizations  
13 is seated on the council: the Canadian Conference of Phar-  
14 maceutical Faculties, the Canadian Society of Hospital  
15 Pharmacists, the Section of Industrial Pharmacists of the  
16 Canadian Pharmaceutical Association.

17               THE CHAIRMAN: Just to be clear, is there any  
18 special significance attached to the term "commercial  
19 pharmacy organization" within the Province?

20               MR. TURNBULL: There are in each province sir  
21 organizations - in most provinces - I stand corrected -  
22 voluntary organizations of retail pharmacists.

23               THE CHAIRMAN: That is what is meant by  
24 commercial pharmacy?

25               MR. TURNBULL: That is correct.

26               MR. COOK: This would be as distinct from  
27 the statutory bodies who have the education and discipline.

28               MR. TURNBULL: The Association acts as a  
29 liaison and co-ordinating organization to represent the  
30 profession of Pharmacy at the national level. It has no





1 authority to impose its decisions on the constituent  
2 statutory organizations who retain complete responsibility  
3 for the profession in their respective provinces. Neither  
4 are its decisions imposed upon the work of other organiza-  
5 tions, nor upon the individual members, namely the active  
6 pharmacy practitioners and other qualified pharmacists  
7 whose names appear on the registers of the constituent  
8 statutory organizations.

9           The Association, since its inception, has  
10 been headquartered in offices located in the City of  
11 Toronto. It is financed by monies received from its  
12 provincial constituent members on the basis of an annual  
13 per capita fee structure. Additional essential revenue  
14 is derived from the balance of income over expenditure  
15 resulting from certain internal activities and services  
16 such as the publication of the "Canadian Pharmaceutical  
17 Journal" and other publications. The C.Ph.A. is a non-  
18 profit professional association dedicated to its principal  
19 objectives as stated in an earlier paragraph.

20           By bylaw, the Association holds an annual  
21 meeting, both general and of its Council, as well as a  
22 semi-annual meeting of its Executive Committee. In  
23 addition, quarterly meetings of its Executive Officers may  
24 be held, as may special meetings of its committees. The  
25 president and two vice-presidents are elected for a term  
26 of one year by Council from its membership. The secretary-  
27 manager is the senior permanent official of the Association.  
28 He is appointed by Council under the bylaws which provide  
29 for the appointment(s) of one or both, of a general manager  
30 and of a secretary-treasurer.



1                   The Commission, during its mid-summer hearings  
2 in various regions of Canada, received representations from  
3 several provincial pharmaceutical associations. There are  
4 many pharmaceutical organizations and organizations of  
5 pharmacists which have a relationship, either direct or  
6 indirect, to the Canadian Pharmaceutical Association.  
7 In Appendix A, attached to this brief, these organizations  
8 are briefly described so that the Commission may be made  
9 more familiar with them and their purposes. In brief,  
10 there are:

11                   (a) provincial statutory pharmacy organiza-  
12 tions established by provincial legislation.  
13 These organizations, called associations,  
14 societies or colleges, have statutory obliga-  
15 tions under the Pharmacy Act of their respec-  
16 tive province, which include the licensing of  
17 those who may practise pharmacy in the  
18 province, the control and discipline of their  
19 own members, and, in general, the regulating  
20 of both the conditions under which pharmacy  
21 may be practised and the dispensing and sale  
22 of drugs and medicinal preparations in their  
23 respective provinces;

24                   (b) voluntary provincial pharmacy organiza-  
25 tions have been formed in most provinces  
26 with the membership thereof generally confined  
27 to pharmacists within a specific vocation or  
28 field of pharmaceutical endeavour (e.g.,  
29 retail pharmacists; hospital pharmacists).  
30 The voluntary organizations of retail



1 pharmacists devote their attention to matters  
2 pertaining to specific aspects of the retail  
3 practice of pharmacy and to common business  
4 interests. Provincial organizations of  
5 hospital pharmacists are, in the main,  
6 constituted as provincial branches of the  
7 Canadian Society of Hospital Pharmacists  
8 and devote their attention to the enhancement  
9 of hospital pharmacy practice and the role  
10 which pharmacists play in the general  
11 organizational pattern of hospitals;  
12 (c) district and local voluntary organiza-  
13 tions of pharmacists may exist and may be  
14 affiliated either directly or indirectly  
15 with the provincial voluntary organizations.  
16 In large urban communities there may be more  
17 than one pharmacists' organization with  
18 membership more or less comprised of pharma-  
19 cists having a common meeting ground other  
20 than Pharmacy, such as religion or language.  
21 District and local organizations are not  
22 directly affiliated with the Canadian Pharma-  
23 ceutical Association, but the individual  
24 members of such are members of the Association  
25 by virtue of their licensing registration  
26 with their provincial statutory pharmacy  
27 organization;  
28 (d) the Canadian Conference of Pharmaceuti-  
29 cal Faculties, formed to deal with all phases  
30 of pharmaceutical education, has as its



1 members, the individual schools, faculties  
2 and colleges of Pharmacy, of which there are  
3 eight;

4 (e) the Canadian Society of Hospital Pharma-  
5 cists, with provincial or regional branches  
6 responsible to its national council, is a  
7 voluntary organization of hospital pharma-  
8 cists formed to improve the standards of  
9 practice of Pharmacy in hospitals;

10 (f) the Section of Industrial Pharmacists  
11 of the C.Ph.A. is a voluntary national orga-  
12 nization of individual pharmacists employed  
13 in the Canadian pharmaceutical industry who  
14 are also members of the C.Ph.A. Here it is  
15 emphasized, for the sake of clarity, that the  
16 Section bears no relationship to the Canadian  
17 Pharmaceutical Manufacturers' Association  
18 which has, as its members, certain companies  
19 engaged in the pharmaceutical industry; that  
20 is, companies as opposed to individuals;

21 (g) the Conference of Pharmacy Registrars  
22 of Canada is a specialized organization,  
23 comprised of the registrars of the provincial  
24 statutory pharmacy organizations, which meets  
25 annually to consider administrative problems  
26 of mutual interest;

27 (h) the Canadian Academy of the History of  
28 Pharmacy, having as its objective the advance-  
29 ment of interest in the history of Pharmacy  
30 in Canada, has a non-restricted membership



1 comprised of individual pharmacists and non-  
2 pharmacists, as well as corporate members;  
3 (i) the Canadian Foundation for the Advance-  
4 ment of Pharmacy is comprised of individual  
5 pharmacists and of corporate members with  
6 the object of providing financial support  
7 for Canadian pharmaceutical education and  
8 research by means of grants to faculties and  
9 by scholarships, bursaries and loans to indi-  
10 vidual students.

11 FUNCTIONS AND ACTIVITIES OF C.PH.A.

12 Because the C.Ph.A. is a Canada-wide organi-  
13 zation of provincial pharmaceutical bodies and has, as its  
14 members, all pharmacists registered with provincial statu-  
15 tory associations, it functions to represent Pharmacy as a  
16 whole at the national and international levels. Too, it  
17 serves as a co-ordinating and liaison body at the provin-  
18 cial level to assist in administrative problems related to  
19 the rendering of pharmaceutical services. The activities  
20 of the Association may be generally illustrated by its  
21 committee structure, the terms of reference of which  
22 outlined fully in Appendix B.

23 I will leave it to you Mr. Chairman whether  
24 you wish these read.

25 THE CHAIRMAN: We can read them. Have you  
26 anything you wish to point out with regard to these?

27 MR. TURNBULL: No. They are presented here  
28 for the information and orientation of the Commission.

29 THE CHAIRMAN: They cover a wide variety of  
30 functions. Of course, the standing committees are what





1 you might expect but the others cover quite a wide variety  
2 of functions operating - some operating within the scope  
3 of your activities. I don't think it is necessary to read  
4 them.

5 MR. TURNBULL: The standing committees, as  
6 provided for in the bylaws, are:

- 7 --- the Executive Committee
- 8 --- the Merchandising Committee
- 9 --- the Bylaws Committee (and a Policy  
10 Planning Sub-Committee)
- 11 --- the Finance Committee
- 12 --- the Publishing Committee
- 13 --- the Nominating Committee

14 The special committees and their sub-commit-  
15 tees are:

- 16 --- the Public Relations Committee (with its  
17 Sub-Committees on History, Pharmacy Week  
18 and Vocational Guidance)
- 19 --- the Professional Relations Committee  
20 (with its Sub-Committees on Interprofes-  
21 sional Relations, Intraprofessional Rela-  
22 tions and the Status of Pharmacists in  
23 Government Service)
- 24 --- the Pharmacy Examining Board of Canada  
25 Organizational Committee
- 26 --- the Pharmaceutical Economics Committee  
27 (with its Sub-Committees on Intertrade  
28 Relations, Pricing Methods, and Surveys)
- 29 --- the Government Liaison Committee (with  
30 its Sub-Committees on Civil Defence,



1 Health Insurance, and Legislation)

2 --- the Health Matters Study Committee

3 --- the Building Committee (with its Advisory  
4 Sub-Committee and provincial advisory  
5 members)

6 On the following pages, Mr. Chairman, we  
7 devote several pages to definitions. Now we realize that  
8 this brief is lengthy. I could say I did not have time  
9 to write a short one. For the sake of the time of the  
10 Commission would you wish to take these as read sir?

11 THE CHAIRMAN: I am not going to insist on  
12 you reading them, but if the definitions you use here are  
13 going to be referred to and have a bearing on the use of  
14 the words subsequently used perhaps you'd better have them  
15 read so we will be sure we know what you are talking about.

16 MR. TURNBULL: DEFINITIONS. The following  
17 definitions are presented to ensure a uniform interpreta-  
18 tion of certain terms as they are used by the Association  
19 in its brief.

20 (1) Pharmacy is that profession which is  
21 concerned with the art and science of prepa-  
22 ring from natural and synthetic sources,  
23 suitable and convenient materials for distri-  
24 bution and use in the diagnosis, treatment  
25 and prevention of disease. It embraces a  
26 knowledge of the identification, selection,  
27 pharmacologic action, preservation, combina-  
28 tion, analysis, and standardization of drugs  
29 and medicines. It also includes their proper  
30 and safe distribution and use, whether



1 dispensed on the prescription of a licensed  
2 physician, dentist, or veterinarian, or, in  
3 those instances where it may legally be done,  
4 dispensed or otherwise made available to the  
5 consumer.

6 (2) Pharmacist: A pharmacist is one who,  
7 through academic qualification and legal  
8 professional registration, is responsible for  
9 the preparation and distribution of the dosage  
10 forms of drugs. The pharmacist practises his  
11 profession through the compounding and dispen-  
12 sing of medical prescriptions, and through  
13 the comprehension and dissemination of infor-  
14 mation related to the science which embraces  
15 all knowledge of drugs, their identification,  
16 mechanism of action, toxicity, therapeutic  
17 activity, palatability, stability, dosage  
18 form, potentiality with other drugs and syner-  
19 gism in combination, and includes the stan-  
20 dardization and critical evaluation of medi-  
21 cinal agents and pharmaceutical preparations.  
22 The pharmacist's duties include general  
23 supervisory control combined with certain  
24 specific legal responsibilities relative to  
25 certain drugs, in addition to direct obliga-  
26 tions concerning the purchase, storage and  
27 safeguarding, and distribution of drugs, in  
28 bulk chemical state or finished pharmaceu-  
29 tical form, whether such duties pertain to  
30 advisory, technical or administrative



1 functions or to his occupation as a pharmacy  
2 practitioner.

3 Further, a pharmacist may be more generally  
4 referred to as a person who has a stipulated  
5 academic background to enable his registra-  
6 tion with a provincial statutory pharmacy  
7 organization.

8 A pharmacy practitioner is a pharmacist  
9 registered and licensed by a provincial  
10 statutory pharmacy organization to prepare,  
11 compound and dispense prescriptions of duly  
12 authorized physicians, dentists and veteri-  
13 narians, intended for the mitigation, treat-  
14 ment or prevention of disease in man or ani-  
15 mal. Such pharmacy practice may be carried  
16 out at the consumer level in community loca-  
17 tions, usually in conjunction with, or as  
18 part of a retail business establishment, or  
19 at the institutional level, normally in  
20 conjunction with a hospital or other treat-  
21 ment centre.

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1 (3) Prescription drug or prescription drug  
2 preparation is any medication which is com-  
3 pounded and/or dispensed by a pharmacist  
4 pursuant to a prescription or other legal  
5 order, either written or verbal, of a physi-  
6 cian, dentist or veterinarian. It is to be  
7 noted that such definition does not confine  
8 the term as referring only to drugs and  
9 preparations thereof restricted to prescrip-  
10 tion-only sale by a specific piece of legis-  
11 lation. The definition does pertain to all  
12 drugs and preparations thereof as supplied on  
13 a prescription or other order of a medical,  
14 dental or veterinary practitioner, whether  
15 compounded in whole or in part by a pharmacy  
16 practitioner, or dispensed in a dosage form  
17 prepared by a manufacturer or a person other  
18 than a pharmacy practitioner.

19 (4) Drug, as defined in the Food and Drugs  
20 Act, "includes any substance or mixture of  
21 substances manufactured, sold or represented  
22 for use in (i) the diagnosis, treatment,  
23 mitigation or prevention of a disease, dis-  
24 order, abnormal physical state, or the symp-  
25 toms thereof, in man or animal, (ii) resto-  
26 ring, correcting or modifying organic func-  
27 tions in man or animal, or (iii) disinfection  
28 in premises in which food is manufactured,  
29 prepared or kept, or for the control of ver-  
30 min in such premises" and further to that





1 definition, as an adjunct to subsections (i)  
2 and (ii) in the foregoing extract from Section  
3 2 of the Act, that such substance or mixture  
4 of substances is prepared for administration  
5 or consumption in a pharmaceutical form as  
6 differing from constituting a portion of, or  
7 an additive to a common food or feed stuff or  
8 are in bulk chemical or natural form.

9 (5) Classification of drugs: Various para-  
10 graphs of the Director's Statement classify  
11 or define drugs in different ways. It is  
12 pointed out in paragraph 6 that sales of the  
13 so-called ethical drugs are "subject to  
14 various restrictions and differ from the  
15 sales of ordinary commodities in several  
16 ways", while "sales of proprietary drug pro-  
17 ducts....are similar to sales of most other  
18 commodities". Later, in paragraph 13, broad  
19 classifications are related to legislation  
20 as it affects the manufacture, distribution  
21 and control at both the federal and provin-  
22 cial legislative levels. In paragraph 17,  
23 it is pointed out that under the Food and  
24 Drugs Act, a drug may be generally defined  
25 according to its intended purpose.

26 (6) Nomenclature: Drugs and drug prepara-  
27 tions may be called by one or all of three  
28 types of names, namely, (i) chemical name  
29 and/or official name; (ii) generic, common or  
30 proper name; (iii) registered brand or trade



1 name. It is emphasized, however, that in  
2 all definitions and classifications of  
3 substances which are part of pharmaceutical  
4 services that such are drugs if (a) it is  
5 the intent of such for use in the diagnosis,  
6 mitigation, prevention or treatment of  
7 disease, or (b) such does have an actual  
8 effect on the normal metabolism of the body  
9 and (c) such are prepared in a pharmaceuti-  
10 cal form as distinct from common, edible  
11 substances or bulk chemical or natural form.

## 12 HISTORY

13 Since the year 1900 and, in particular,  
14 during the past two or three decades, radical changes  
15 have been brought about in our day-to-day living through  
16 the many wonderful developments which are, today, almost  
17 commonplace. Startling developments in drugs have saved  
18 countless lives and have helped to lengthen the life span  
19 by more than 20 years. These developments have so altered  
20 the nature of the practice of Pharmacy that an indivi-  
21 dual's preparation for it has been drastically changed to  
22 meet modern challenges.

23 Today, there is a clear distinction between  
24 medical practice, that of diagnosing and prescribing  
25 treatment for illness, and pharmaceutical practice which,  
26 in a broad sense, extends to the responsibilities to be  
27 borne as an expert on drugs, and includes responsibility  
28 for the preparation, testing, preserving, compounding and  
29 dispensing of drugs as may be required to meet the diag-  
30 noses established by medical practice. In history,



1 however, one person in a community often performed both  
2 functions, with the religious leaders of early civiliza-  
3 tions combining the treatment of disease and the prepara-  
4 tion of crude medicines with religious practices. Drug  
5 action actually resulting from applied concoctions or  
6 orally administered foods to sick patients were usually  
7 credited to some element of superstition and such super-  
8 stition continued well into the 20th century, even in  
9 advanced civilizations. Hippocrates possibly was the  
10 first to introduce a measure of rationalization into the  
11 treatment of the sick. For many centuries, the functions  
12 of physicians and compounders of medicine overlapped and  
13 naturally occurring substances of nature or extracts pre-  
14 pared from them constituted the only *materia medica*.

15 In 1240 A.D., the Emperor of the Two Sicilies  
16 issued a decree that pharmacy should be separated from  
17 medicine, as each required the exercise of a special skill  
18 and knowledge and that it was, therefore, in the interest  
19 of public health that neither should do the work of the  
20 other. Thus, there developed a new specialization which  
21 created an awareness of the need for medicines of consis-  
22 tent uniformity. Uniformity and standards were stipulated  
23 in official publications such as formularies and pharma-  
24 copoeias, first prepared by city governments, and later by  
25 national governments. During the Middle Ages, the guild  
26 system emphasized standards of qualification for entrance  
27 to the practice of various professions and in the apothecaries' guilds, placed additional emphasis upon standards  
28 for drugs. Plant chemistry had its beginning as a more  
29 scientific attitude gradually developed in France and  
30



1 Germany, placing emphasis upon pharmaceutical chemistry,  
2 as opposed to galenical pharmacy. This new chemistry  
3 provided pure crystalline chemical extracts from crude  
4 plant drugs to enable a new purity and potency of active  
5 principals. Later, organic chemistry brought the synthe-  
6 sis of animal compounds in 19th century, and the discovery  
7 of microorganisms as the cause of infectious diseases  
8 brought forth the development of antitoxins and vaccines.

9 THE CHAIRMAN: I would like to display my  
10 ignorance of what the term galenical means.

11 MR. TURNBULL: Galenical is used as an  
12 adjective. It is an outgrowth from the name of a man,  
13 Galen who prepared many drugs from naturally occurring  
14 substances; very briefly vegetable drug preparations.

15 It was in the 19th century that certain  
16 enterprising apothecaries began to make a specialty of  
17 producing a few products on a larger scale for sale to  
18 other apothecaries or pharmacists. Thus, the pharmaceu-  
19 tical industry had its beginning in the pharmacist's  
20 dispensary or, as called in those days, the apothecary's  
21 compounding room. The German pharmacist, Merck of Darm-  
22 stadt, began in this way with morphine. Allen and Han-  
23 burys of England, and Schering of Germany had similar  
24 beginnings. In North America, Parke, Davis and Company  
25 sprang from a pharmacy where cascara had its origin.  
26 Lilly, Smith Kline and French and Wyeth had similar  
27 beginnings, while Upjohn, Squibb and Lederle were initi-  
28 ated by physicians. In each case, the desire to make one  
29 or a few products just a little better and on a larger  
30 scale was the incentive.





1 Scientific medicine began about the begin-  
2 ning of the 20th century as "chemotherapy" when products  
3 originating in the laboratory became a powerful weapon in  
4 the fight against disease. From the laboratory came our  
5 coal tar derivatives, including the sulpha drugs and other  
6 synthetic therapeutic agents all requiring the special  
7 ability and equipment of the researcher and the production  
8 manufacturer to produce disease weapons which bear little  
9 relationship to the hit-and-miss preparations of the past.

10 Within the past few decades, there are  
11 developments which tax the imagination as we view the anti-  
12 biotics, the antihistamines, the tranquilizers and psycho-  
13 tropic drugs, corticosteroids, the vitamins (including  
14 Vitamin B , the most potent anti-anemic substance known),  
15 the vaccines (including Salk vaccine and now, the oral  
16 polio vaccine), the oral anti-diabetic drugs and many  
17 others. Today's system of laboratory preparation of speci-  
18 fic synthetic compounds has, in an extremely short period  
19 of time, yielded active, therapeutically useful compounds  
20 which have almost entirely replaced the relatively ineffec-  
21 tive medications of the early 1900's.

22 Thus, the medical practitioner has for the  
23 treatment dictated by his diagnosis, specific drugs and  
24 medications which are forever being replaced by even more  
25 superior drugs. All contribute to the health of the public  
26 which experiences shorter periods of illness and greater  
27 longevity.

#### 28 PHARMACEUTICAL EDUCATION IN CANADA

29 The evolution in drugs and medicines briefly  
30 outlined in the foregoing has made necessary substantial





1 adjustments in pharmaceutical education and practice  
2 during the past three decades. While still required to  
3 have an expert ability which will enable him to exercise  
4 the technical and manipulative skills required in the pre-  
5 paring, preserving, compounding and dispensing of drugs,  
6 the pharmacist of today is required to have superior know-  
7 ledge of the great multitude of prescription and other  
8 drugs so that he may exercise mature judgment in dealing  
9 with confidential matters involving the patient and the  
10 physician, as well as in dealing directly with the public  
11 in the sale of drugs. Basically, the pharmacy practitioner  
12 is a specialist in the science of drugs and in this capa-  
13 city stands as one of the guardians of the health of his  
14 community where he practises. Few modern prescriptions  
15 require the exercising of the ancient art of the apothecary,  
16 but they do demand much more of a pharmacist's  
17 scientific knowledge respecting the medicines prescribed.  
18 He is the custodian of poisons and the specialist in the  
19 science of drugs, responsible for the quality and the  
20 integrity of the drugs which he dispenses, and sharing  
21 responsibility if harm ensues from prescribed overdoses.  
22 His training is such that, by law, he is expected to pro-  
23 tect equally the physician and the patient.

24                   Pharmaceutical service, today, implies the  
25 assumption by the pharmacist of a heavy professional  
26 responsibility in the utilization of the basic scientific  
27 knowledge which he possesses. The rendering of pharma-  
28 ceutical service is not a mere expansion of a simple  
29 commercial transaction which requires nothing more than  
30 the ability to correctly read labels and transfer



1 medications.

2                   The fact that Pharmacy is customarily prac-  
3 tised as a part of a retail business establishment has  
4 brought about certain conflicts between scientific require-  
5 ments, professional ethics and the desire....indeed the  
6 need....to make a profit. Only in a minority of busi-  
7 nesses has commerce in medicinals been sufficient for the  
8 successful maintenance of a strictly professional pharmacy  
9 and thus, the drug store has evolved under the conditions  
10 of a free enterprise economy to its presently known form.  
11 The individual pharmacist has become less a compounder of  
12 medicinals and more a scientific purveyor of services and  
13 a technical adviser with an expanded scope of opportunities  
14 for the application of his professional abilities and  
15 knowledge.

16                   From what was essentially an apprenticeship  
17 system at the beginning of the century, the study of  
18 Pharmacy may now be viewed as an academic discipline with  
19 certain non-professional studies being an essential part  
20 of the preparation of the pharmacist. Formally, pharma-  
21 ceutical education in Canada commenced soon after the time  
22 of Confederation when, in 1892, a teaching college,  
23 originally established in 1882 under the prerogatives  
24 granted the Ontario College of Pharmacy, was affiliated  
25 with the University of Toronto. As the provinces or terri-  
26 tories were formally constituted, pharmaceutical associa-  
27 tions were made responsible for the educational and licen-  
28 sing qualification of pharmacists, thus initiating formal  
29 courses which, as the demand for further pharmaceutical  
30 education increased, were given over to the universities



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1 within the provinces. Today, there are eight colleges or  
2 schools of Pharmacy in Canada, one in each of the provinces  
3 of British Columbia, Alberta, Saskatchewan, Manitoba and  
4 Ontario; two in Quebec and one in the Maritime Provinces.  
5 In each instance, they are established within a university  
6 and are responsible for all of the theoretical education  
7 of a pharmacist. The degree awarded is that of Bachelor  
8 of Science in Pharmacy. In Newfoundland, pharmaceutical  
9 education is carried out by the statutory association and  
10 is not presently affiliated with a university.

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1 The need for a definite co-ordination of  
2 effort prompted the Canadian Pharmaceutical Association to  
3 bring together representatives of each Pharmacy college  
4 in August of 1944, with the consequent formation of the  
5 Canadian Conference of Pharmaceutical Faculties. This  
6 organization has greatly enhanced pharmaceutical education  
7 in Canada by co-ordinating and standardizing the curriculum  
8 as taught in each of the colleges and providing for a four  
9 year course which would permit specialization in retail  
10 pharmacy, hospital pharmacy and manufacturing pharmacy,  
11 as well as preparing students for graduate studies. Students  
12 from many countries --- India, Pakistan, Formosa, Thailand,  
13 Hong Kong, Nigeria, Cuba, Trinidad, in addition to several  
14 European countries --- have studied Pharmacy in Canada.

15 THE CHAIRMAN: I suppose you have not any  
16 data on what proportion of students come from outside  
17 countries to study in Canada?

18 MR. TURNBULL: The proportion?

19 THE CHAIRMAN: What proportion?

20 MR. TURNBULL: I think percentage-wise it  
21 would be quite small, Mr. Chairman.

22 THE CHAIRMAN: There were quite a number of  
23 students who came from the West Indies for one purpose or  
24 another, but they were not all studying pharmacy?

25 MR. TURNBULL: No.

26 THE CHAIRMAN: But those are the areas from  
27 which you get many of your extra-territorial students?

28 MR. TURNBULL: Yes. I think we could possibly  
29 check into that.

30 THE CHAIRMAN: It is not of any real



1 importance. I was just wondering what significance it  
2 might have.

3 MR. TURNBULL: I know there are many other  
4 countries that are not listed here, for example,

5 In Appendix C, pharmaceutical education in  
6 Canada is discussed more fully but without specific reference  
7 to the curriculum of any one academic institution in which  
8 such education is available. It is worthwhile including  
9 in this discussion before the Commission the more specific  
10 objectives of the academic program for Pharmacy:

11 1. Select, screen, and graduate those students  
12 possessing the technical abilities, personal  
13 character and social outlook required in the  
14 practice of pharmacy.

15 THE CHAIRMAN: That is quite a job, isn't  
16 it?

17 MR. TURNBULL: I think the educators would  
18 agree with you.

19 THE CHAIRMAN: I seem to recall some  
20 difficulties with regard to selecting students for the  
21 profession of medicine. They had some difficulty in  
22 deciding in one province I know quite a bit about based  
23 on character and social outlook, and that sort of thing.  
24 They had a great deal of difficulty in deciding between  
25 one person and another who would be better, because it does  
26 not always work out after they have completed their course  
27 that they have made a good selection.

28 MR. TURNBULL:

29 2. Teach students to procure, develop, prepare,  
30 preserve, standardize, test, and dispense





- 1 substances and articles used in the diagnosis,
- 2 treatment and prevention of disease.
- 3 3. Develop the ability in students to utilize
- 4 properly official pharmacopoeias, formularies
- 5 and other recognized reference works on
- 6 drugs.
- 7 4. Ground students in the principles and
- 8 practices of organizing and administering a
- 9 pharmacy.
- 10 5. Make students fully conscious of the ethical
- 11 and moral standards to be met by the
- 12 pharmacist.
- 13 6. Qualify students to co-operate with members
- 14 of the other health professions and to
- 15 consult with them; to furnish accurate,
- 16 objective and scientific information to
- 17 physicians and members of other health
- 18 professions concerning drugs and their action.
- 19 7. Prepare students to provide professional
- 20 services to the public appropriate to the
- 21 basic functions of pharmacy in its role as
- 22 a health profession.
- 23 8. Equip and stimulate students to contribute
- 24 to the profession by participating at its
- 25 various levels - association activities,
- 26 organization, education, research, etc.
- 27 9. Provide students with an adequate founda-
- 28 tion for graduate work in the various subjects
- 29 of the curriculum.
- 30 10. Prepare students to assume the responsibilities



of citizenship befitting professionals.

11. Attempt to enrich the life of the students by stimulating them to greater understanding and appreciation of the culture, values and problems of our civilization.

MANPOWER

In the Director's Statement, paragraph 126, reference is made to a suggestion that "the number of pharmacists graduating is not keeping pace with the increase in population and the number of retiring pharmacists". It is well known that many pharmacies have available the services of only one pharmacist because no second pharmacist can be obtained, or because the economy of that pharmacy's operation could not support an additional pharmacist. Possibly, either one or both of these factors could be the result of a disproportionate number of pharmacy establishments in relation to the needs of the population of any specific area or urban location.

THE CHAIRMAN: I suppose your Association has not reached any conclusions on that point?

MR. TURNBULL: At this point, no sir. We are making further reference, doing a tremendous amount of work at the moment in connection with the so-called Hall Commission, or the Commission on Health Services. We have made some definite recommendations in that regard.

However, it is not the purpose of this submission to review or debate the various considerations related to the efficient allocation of professional resources, nor to attempt to assess the quantitative requirement of pharmacists to meet the needs of an expanding



1 Canadian population, or to determine the adequate staffing  
2 by pharmacists of a greatly expanded field of pharmaceutical  
3 endeavour in our nation.

4                   The next paragraphs were read earlier. I  
5 will ask that they be recorded at this particular place,  
6 and I would request also that the tables as presented in  
7 this presentation be taken as read and written into the  
8 record unless they have particular significance.

9                   THE CHAIRMAN: Yes.

10                  MR. TURNBULL: The reporters have a copy  
11 of our presentation.

12                  The records of the Canadian Pharmaceutical  
13 Association as of June 30, 1961, indicate a membership  
14 total of 8940 pharmacists, 63 of whom reside in countries  
15 other than Canada, and the balance, by vocation, as follows:

16       Owners, managers or partners of retail	
17       pharmacies	- 5357
18       Pharmacist- employees in retail pharmacies	- 2620
19       Hospital Pharmacists	- 392
20       Pharmacists employed in industry	- 271
21       Pharmacists in government and armed forces	- 39
22       Professors, graduate students	- 51
23       Miscellaneous categories	- 147

24                  The foregoing, regrettably, cannot be  
25 considered as a completely accurate breakdown of our member-  
26 ship listing according to pharmaceutical vocation or endeavour,  
27 as the Association's flow of information is not always  
28 completely up-to-date in the face of movements within the  
29 profession and the different methods of record keeping on  
30 the part of the provincial statutory pharmacy organizations



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- 1 from which the Association receives its information. A
- 2 further breakdown is presented in Table 1.

TABLE I

	Owners, Mgcs.	Hosp. Phcsts.	Phcsts. in Ind.	Govt. & Mil.	Teach., etc.	Misc.	Phost.- Employees	TOTAL REGISTRATION
June, 1961								
B.C. & Yukon	498	38	46	5	3	22	529	1146
Alta. & N.W.T.	454	35	5	4	6	24	189	717
Sask.	344	42	7	3	5	5	135	541
Man.	320	31	26	6	4	22	205	594
Ont.	2301	154	123	17	18	33	1185	3931
Que. & Lab.	1080	59	43	-	8	60	264	1514
N.B.	113	10	7	2	-	1	29	162
N.S.	168	17	3	-	2	-	48	238
P.E.I.	24	2	-	-	-	-	8	34
Nfld.	55	4	11	2	-	-	28	100
CANDN. TOTAL	5357	392	271	39	51	147	2620	8877
Foreign	-	6	2	4	6	4	41	63
GRAND TOTAL	5357	398	273	43	57	151	2661	8940

20 THE CHAIRMAN: You don't wish to raise  
21 any particular point with regard to the figures in table  
22 1?

23 MR. TURNBULL: I don't believe so. They  
24 are placed there as representing a further breakdown of  
25 the total figures given concerning the various categories  
26 of pharmacy endeavour.

27 THE CHAIRMAN: It indicates a fairly  
28 substantial variation on the population basis.

29 MR. TURNBULL: Yes.

30 THE CHAIRMAN: In the numbers of pharmacists



1 in one province as compared to another, Ontario has a  
2 total registration of 3831 and Quebec has 1514, substantially  
3 less than half. But they have a great deal more than half  
4 the population of Ontario. That kind of discrepancy is  
5 noticed, but you have not any comments to make on that?

6 MR. TURNBULL: No, I don't believe they  
7 would be significant to anything we are presenting at the  
8 moment, unless there was any specific question relative to  
9 that. In Ontario there are 3831 out of our grand total  
10 of 8940, or approximately 45% of the pharmacist population  
11 resides in the Province of Ontario.

12 THE CHAIRMAN: I noticed also proportionately  
13 the western provinces have more than the maritime province?

14 MR. TURNBULL: That is correct.

15 THE CHAIRMAN: In relation to population.

16 MR. FRAWLEY: Those two large figures of  
17 5357, owners and managers, and 2620, pharmacist-employees,  
18 each of those are licensed members of the College of  
19 Pharmacy?

20 MR. TURNBULL: The total of 8940, sir. The  
21 grand total, each and every one of them is a licensed,  
22 fully licensed registered pharmacist.

23 MR. FRAWLEY: Registered pharmacist?

24 MR. TURNBULL: I have to qualify the "fully  
25 licensed" part of it. I can use myself for an example.  
26 I am a registered pharmacist in Saskatchewan, but I am not  
27 licensed to practise although I maintain registration.

28 MR. FRAWLEY: You are sort of an inactive  
29 pharmacist or something?

30 MR. TURNBULL: That is correct.





1 THE CHAIRMAN: There is a point of note.  
2 Perhaps it is of no great importance. It is under the  
3 heading "Government and Military". The total is only  
4 39. Would that include all the pharmacists in all the  
5 government hospitals?

6 MR. TURNBULL: As I mentioned earlier, we  
7 have difficulty keeping track of people and in some  
8 instances there is a failure in our record keeping. For  
9 example, the D.V.A. hospital pharmacist might be in our  
10 records with a home address instead of his D.V.A. address.  
11 We cannot identify him. He might be in as a hospital  
12 pharmacist and also quite a number of pharmacists employed  
13 in government have gone in because of their qualification  
14 in pharmacy, but over the course of years they have gone  
15 into other channels and possibly have dropped to their  
16 registration and licencing with a provincial licencing  
17 body, so that we have no record of them any longer.

18 THE CHAIRMAN: At first I thought perhaps  
19 there might not be more government hospitals than 39 that  
20 are indicated, but I am inclined to think there are  
21 probably quite a few more than 39 in government and military  
22 hospitals.

23 MR. TURNBULL: Yes.

24 THE CHAIRMAN: To say nothing of those who  
25 are in government service in the Department of Health and  
26 so on.

27 MR. TURNBULL: It depends upon their  
28 registration, whether they see fit to maintain their  
29 registration. I could express my viewpoint on this, but  
30 it does not pertain to the purpose of the brief.



1 THE CHAIRMAN: Those are the ones which your  
2 records point to specifically as being engaged in govern-  
3 ment or military establishments?

4 MR. TURNBULL: That is correct.

5 MR. FRAWLEY: Who are the miscellaneous  
6 gentlemen?

7 MR. TURNBULL: Like in any profession, we  
8 have pharmacists who have maintained records that might  
9 now be lawyers or insurance brokers. I know of two who  
10 are ministers of the cloth and I know one who is a second  
11 hand car salesman. That is the kind of thing we cannot  
12 categorize in any pharmacy endeavour, but they have seen  
13 fit to maintain their pharmacy registration.

14 THE CHAIRMAN: In effect they are practising  
15 pharmacists?

16 MR. TURNBULL: That is correct.

17 THE CHAIRMAN: They are engaged in some other  
18 occupation?

19 MR. TURNBULL: Correct.

20 Enrolment of students in Canadian Colleges  
21 of Pharmacy for the period 1947 - 1960, inclusive, is  
22 presented in Table II, as extracted from the report of the  
23 Committee on Enrolments of the Canadian Conference of  
24 Pharmaceutical Faculties, August, 1961. From it, it can  
25 be seen that Pharmacy colleges have, more or less, main-  
26 tained a stable enrolment as a percentage of the total  
27 enrolment in the eight universities of which they are a  
28 part, with the highest years being 1950 and 1951, (at 3.6%),  
29 resulting from high post war enrolments.



TABLE II

Year	Total Enrol- ment in Cana- dian Universities	Total Enrol- ment in Pharmacy	% of Total	Total En- rolment in 8 Univer- sities*	% of Total
1947	76896	1306	1.7	51612	2.5
1948	73172	1448	2.0	48486	3.0
1949	66486	1436	2.1	40124	3.3
1950	59914	1394	2.3	38755	3.6
1951	57301	1369	2.3	37853	3.6
1952	56589	1385	2.4	39158	3.5
1953	58905	1272	2.2	38913	3.3
1954	62291	1207	1.9	39994	3.0
1955	66277	1198	1.8	42329	2.8
1956	72629	1145	1.6	45976	2.5
1957	80443	1109	1.4	50164	2.2
1958	88010	1268	1.4	55356	2.3
1959	94928	1385	1.5	58844	2.4
1960	105911	1482	1.4	65931	2.2

\*Enrolment in Canadian Universities  
having Schools or Colleges of  
Pharmacy.

Enrolments have not followed any parti-  
cular pattern of change, and, indeed, as may be seen  
from Table III, they fluctuated greatly during the survey  
period, 1947 - 1960. In passing, it might be commented  
that Pharmacy, like certain other professions, has viewed  
with concern the problems of vocational guidance and the  
need to better its student recruitment work. During recent  
years this has received much attention on the part of the  
Association and the colleges and is of specific concern



1 to the Canadian Foundation for the Advancement of Pharmacy.  
2 Such activities may account for the increasing enrolments  
3 exhibited in the chart in the 1958, 1959 and 1960 figures,  
4 although it is pointed out that the increases of these  
5 years are also the result of more extensive physical  
6 facilities being made available in certain colleges which  
7 had previously been much more limited.

8 THE CHAIRMAN: Do you mean they were kept  
9 out previously by physical limitations on the part of the  
10 College of Pharmacy?

11 MR. TURNBULL: Yes. I think the best  
12 example to use would be a current example, sir. Manitoba,  
13 I believe, is restricted to 55 new enrolments, while at  
14 the same time by next fall they will have their new school  
15 of pharmacy constructed and their enrolment possibilities  
16 may increase very, very much.

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1 Now, during the past decade or 15 years,  
2 Alberta has greatly expanded its facilities. I believe  
3 British Columbia and certain of the other schools and  
4 colleges have had made available to them, once the post  
5 war rush was over, more physical facilities and space

6 THE CHAIRMAN: In the immediate post war  
7 period there were almost as many as in 1960.

8 MR. TURNBULL: That is correct.

9 THE CHAIRMAN: It must have been rather  
10 crowded then.

11 MR. TURNBULL: We almost sat in one  
12 another's laps.

13 THE CHAIRMAN: Were there limitations in  
14 lecture rooms?

15 MR. TURNBULL: Lecture space, laboratory  
16 accommodations, and all that type of thing.

17 THE CHAIRMAN: In medicine it would be  
18 clinical material, but it would not be exactly the same  
19 reason in pharmacy. The laboratory facilities might be  
20 more difficult to handle than lecture space. They needed  
21 larger rooms or more chairs?

22 MR. TURNBULL: I believe now every student  
23 would have his own laboratory locker, whereas when Mr.  
24 Summers and I went to university, the same university  
25 about the same time, we had four people using the same  
26 locker. I don't know whether students today get started  
27 at eight o'clock and go to about eight or nine at night,  
28 but we had to do that.

29 THE CHAIRMAN: Double series of lectures,  
30 and that sort of thing?

MR. TURNBULL: That is right.





/EMT/nm

TABLE III

Year	Total Enrol-ment	Change	% Change	Total Pharma-cy Enrolment	Change	% Change
1947	76896			1306		
1948	73172	-3724	- 4.8	1448	+ 142	+10.9
1949	66486	-6686	- 9.1	1436	- 12	- 9.8
1950	59914	-6572	- 9.8	1394	- 42	- 2.2
1951	57301	-2613	- 4.4	1369	- 25	- 1.8
1952	56859	- 712	- 1.2	1385	+ 16	+ 1.2
1953	58905	+2316	+ 4.1	1272	- 113	- 8.1
1954	62291	+3386	+ 5.9	1207	- 65	- 5.1
1955	66277	+3986	+ 6.4	1198	- 9	- 0.8
1956	72629	+6352	+9.6	1145	- 53	- 4.4
1957	80443	+7814	+10.8	1109	- 36	- 3.1
1958	88010	+7567	+ 9.5	1268	+ 159	+14.3
1959	94928	+6918	+7.9	1385	+117	+9.2
1960	105911	+10983	+11.5	1482	+ 97	+7.0

In a study of this nature, it is significant to view first year enrolments as they give an indication of the interest in Pharmacy of students in the light of changing conditions and situations. It is to be remembered that, in the main, the young student who is considering Pharmacy as a career has knowledge only obtained through literature and discussion and his firsthand observation of the pharmacy practitioner in his community. Quite naturally, literature and publicity have their effect on him, as has the counselling which he receives both from his teachers and his parents. The figures for 1960 enrolment may well indicate the effect on the general public of the adverse publicity which has



1 faced Pharmacy and drug distribution, generally, during  
2 the past 12 to 18 months. First year enrolments are  
3 presented in Table IV and graduations in Table V, and you  
4 will note when based on early reports of admissions,  
5 our enrolments in the Canadian colleges of pharmacy appear  
6 to be down 9.3%.

7 THE CHAIRMAN: The figures for 1961 en-  
8 rolments may well indicate the effect on the general public  
9 of adverse publicity. Is there any evidence of that?

10 MR. TURNBULL: You mean have we ever asked?

11 THE CHAIRMAN: Have you found any number  
12 of young people who have said they had intended to enter  
13 pharmacy, but in view of the adverse criticism, they  
14 thought they would take up something else?

15 MR. TURNBULL: No, we have no figures. We  
16 have no figures that we might present to you on that.

17 THE CHAIRMAN: The table, of course, itself  
18 does fluctuate a great deal.

19 MR. TURNBULL: Yes. It is quite significant.  
20 The reason for placing the table before you was merely to  
21 comment on it. After three years of quite substantial  
22 percentage increases, there was suddenly a drop in en-  
23 rolments.

24 THE CHAIRMAN: On the other hand, between  
25 1952 and 1957 you had successive drops for five years?

26 MR. TURNBULL: That is correct.

27 THE CHAIRMAN: It is hard to reach a  
28 conclusion unless you have some evidence about it.

29 MR. TURNBULL: That is why we use the  
30 terminology "may well indicate".



TABLE IV

FIRST YEAR ENROLMENT IN CANADIAN SCHOOLS OF PHARMACY

Year	Number	Change	% Change
1947	547	-	-
1948	555	+ 8	+ 1.5
1949	519	- 36	- 6.5
1950	485	- 34	- 6.6
1951	387	- 98	- 20.2
1952	412	+ 25	+ 6.6
1953	397	- 15	- 3.6
1954	382	- 15	- 3.8
1955	343	- 39	- 10.2
1956	337	- 6	- 1.7
1957	313	- 24	- 7.1
1958	406	+ 97	+ 30.9
1959	439	+ 33	+ 8.1
1960	567	+ 128	+ 29.1
1961*	514	- 53	- 9.3

\*Based on early reports of admissions

TABLE V

GRADUATES OF CANADIAN SCHOOLS OF PHARMACY

YEAR	NUMBER	CHANGE	% CHANGE
1947	302	-	-
1948	306	+ 4	+ 1.3
1949	407	+ 101	+ 33.0
1950	411	+ 4	+ 1.0
1951	379	- 32	- 7.7
1952	351	- 28	- 7.4
1953	401	+ 50	+ 14.2
1954	332	- 69	- 17.2



1	Year	Number	Change	%Change
2	1955	261	- 91	- 27.4
3	1956	310	+ 49	+ 18.8
4	1957	285	- 25	- 8.1
5	1958	247	- 38	- 13.3
6	1959	284	+ 37	+ 14.9
7	1960	264	- 20	- 7.0

8  
9 As stated previously, a discussion of  
10 manpower in Pharmacy is extremely far-reaching. It is  
11 not believed to be of sufficient importance to this Commission's  
12 review to present its many aspects in this brief. Manpower  
13 surveys have been considered for many years by the  
14 Association but have not been fully undertaken in view of  
15 the extreme limitation imposed by financial and physical  
16 resources. The Association, in its Preliminary Statement  
17 to the Royal Commission on Health Services on September  
18 27, 1961, urged that that Commission undertake such a  
19 research as a vital project and outlined to it a recommended  
20 study. This is appended in Appendix D.

#### 21 LEGISLATION

22 Historically, legislative control over the  
23 practice of pharmacy and the distribution of drugs and  
24 poisons, assumed a measure of significance in the mid-19th  
25 century, following a government request that the  
26 Pharmaceutical Society of Great Britain obtain particulars  
27 related to the sale of poisons, especially arsenic, in the  
28 various parts of the country. The British Pharmacy Acts  
29 of 1852 and of 1868 contained poison schedules and the  
30 latter Act made it an offence for persons not registered



1 by the Society to keep open shop for the retailing,  
2 dispensing and compounding of certain substances named  
3 in those schedules. In its National Insurance Act of  
4 1911, the British Parliament decreed that, in the interests  
5 of those receiving these health services, it should be  
6 spelled out in the Act that it is the physician's function  
7 to diagnose and prescribe and that all dispensing must be  
8 under the supervision of a properly licensed pharmacist.  
9 At the same time, the principle was established that  
10 patients were to have freedom of choice in respect to the  
11 pharmacist to whom any prescription would be submitted and  
12 pharmacists were to be directly represented at the various  
13 administrative levels provided for by the Act.

14 In Canada, the British North American Act  
15 clearly designated health matters as a provincial  
16 responsibility. Thus, pharmacy Acts were passed by  
17 legislatures in Quebec and Ontario in 1870 and 1871,  
18 respectively, and these were followed over a period of  
19 years by similar legislation in other provinces, as well  
20 as a federal ordinance pertaining to the Yukon and  
21 Northwest Territories.

22 At the federal level, legislation based on  
23 constitutional power in relation to criminal law is  
24 intended to protect the consumer from health hazards and  
25 from fraud and deception arising from the sale of drugs.  
26 Provincial legislation concerns itself with matters  
27 respecting property and civil rights and thus, deals more  
28 specifically with the actual distribution of drugs and  
29 professional control over them.

30 Federal statutes affecting the practice of





1 Pharmacy in Canada are the Narcotic Control Act, the Food  
2 and Drugs Act, the Proprietary or Patent Medicine Act,  
3 the Excise Act, in addition to others dealing with  
4 animal and plant life and with pest control products.

5                   Legislation is dealt with more fully in  
6 Appendix E. It is of importance to point out here that  
7 the Canadian Pharmaceutical Association has, throughout  
8 its existence, worked in close harmony with the legislators  
9 of our country and those who are charged with the adminis-  
10 tration of the various statutes and their regulations.  
11 Drugs, as such, are not specifically mentioned in the British  
12 North America Act and, therefore, legislation pertaining  
13 to them involves matters of concern to both federal and  
14 provincial governments. Regulatory control is exercised  
15 at the federal level over the importing, manufacturing  
16 and distribution of drugs, with the responsibility for  
17 the administration of such being vested in the Food and  
18 Drug Directorate of the Department of National Health and  
19 Welfare. The Division of Narcotic Control has specific  
20 duties pertaining to the Narcotic Control Act and, more  
21 recently, to "Controlled Drugs" appearing in Schedule G  
22 of the Food and Drugs Act.

23                   The Canadian Pharmaceutical Association,  
24 as mentioned before, through its head office staff and the  
25 pharmacist-members of advisory committees to the Department  
26 of National Health and Welfare, has enjoyed a close and  
27 cordial relationship with the administrative staff of the  
28 Food and Drug Directorate. Without qualifying our remarks  
29 in any way we emphatically state --- in contradiction to  
30 some pronouncements and not from organized pharmacy, on the



1 same subject --- our honest belief that the Food and Drugs  
2 Act and its regulations are conscientiously administered  
3 by knowledgeable and capable persons operating within the  
4 severe limitations of a restrictive budget. However,  
5 extensive and rapid changes in both the nature and com-  
6 position of modern drugs and in the industry itself have  
7 brought forth evidence that certain problems are not being  
8 surmounted, particularly in the field of drug production  
9 control. With an increasing population and an expanding  
10 manufacturing industry, the Directorate is faced with a  
11 multitude of administrative problems which clearly indicate  
12 that there is a need for more clearly-defined departmentaliza-  
13 tion of, first, 'food' and secondly, of 'drug' control.  
14 The Association has made recommendations in this regard  
15 as part of its submission, dated July 31st, 1961, to the  
16 Royal Commission on Government Organization. This is  
17 attached as Appendix F.

18                   The objectives and philosophy of Canadian  
19 legislation as such pertain to drugs and to standards of  
20 practice of pharmacy may be broadly summarized as:

- 21 1.               The preservation of the traditional British  
22                   distinction between the medical practitioner,  
23                   whose function it is to diagnose and to  
24                   prescribe treatment, and the pharmacist  
25                   whose role, in the broad sense, is to be  
26                   responsible for the preparation, testing,  
27                   preserving, compounding and dispensing of  
28                   drugs; i.e., of substances used in the  
29                   diagnosis, prevention and treatment of  
30                   disease.



MR/dpw

1 2. It is not in the public interest that  
2 there be direct business relationships  
3 between practitioners of medicine and phar-  
4 macy, on the principle that professional  
5 service, not exploitation of the sick,  
6 should be the main function of the healing  
7 professions.

8 3. A specialized knowledge and skill is  
9 necessary in the procurement, preservation  
10 and distribution, to the consumer, of drugs  
11 and such ancillary items as present any  
12 health hazard.

13 4. While not wishing to unnecessarily  
14 restrict the individual's right to self  
15 medicate, it is recognized that those sub-  
16 stances defined as "drugs" in the Food and  
17 Drugs Act, do represent a health hazard and  
18 that there must be certain limitations  
19 placed on their distribution in order to  
20 protect the purchaser from his own ignorance  
21 or from the actions of those who would use  
22 his ignorance, fear or anxiety for their  
23 own gain. This latter objective is held to  
24 apply equally to labelled claims and to  
25 advertising and other promotional measures.

26 5. Further to the above, the necessity also  
27 is recognized of restricting all narcotics  
28 and certain other 'schedule' drugs, as shall  
29 be specified from time to time, to sale only  
30 on the prescription of a recognized



1 practitioner.

2 6. The manufacturer of a drug is required  
3 to make certain that his product meets the  
4 specified standards of purity and potency,  
5 and that it has been prepared under sani-  
6 tary conditions. Furthermore, he must  
7 satisfy the Food and Drug Directorate prior  
8 to marketing a new drug that adequate tests  
9 have been performed to guarantee its safety  
10 when used for the purposes claimed and accor-  
11 ding to the directions given.

12 7. A considerable measure of responsibility  
13 and discretionary authority is vested in  
14 medical and pharmaceutical licensingbodies  
15 to ensure that their practitioners conform to  
16 both the legal and ethical standards in  
17 order that a maximum of public safety may be  
18 maintained with a minimum of restriction on  
19 the use of medicinal substances.

20 THE CHAIRMAN: I think perhaps Mr. Turnbull,  
21 you would welcome a break from all that reading.

22  
23 --- Short Recess  
24

25 MR. TURNBULL: To continue our presentation  
26 under the heading, CONSUMER SOURCES OF DRUGS. Drugs are  
27 available to the consuming public, either generally or to  
28 certain segments thereof, through many sources, some of  
29 which are dealt with more extensively in subsequent sec-  
30 tions of this brief. These sources include:



1. Retail pharmacies
2. Hospital pharmacies: (a) General
3. (b) Private
4. (c) Government -
5. federal; provincial
3. Dispensing physicians: In every province,
- physicians may legally dispense the drugs
- which are required by their own patients.
- Physicians may also, under certain conditions,
- register under the Pharmacy Act to conduct
- a pharmacy practice with services available
- to persons other than their own patients,
- particularly in remote areas where usual
- pharmaceutical service is not available.
- Further, physicians, as well as lay persons,
- may have a financial interest in a pharmacy
- under certain conditions and/or to a limited
- extent.
- In our four most westerly provinces (British
- Columbia, Alberta, Saskatchewan and Manitoba), there are:
- (a) Physicians dispensing from own office
- 73
- (b) Physicians who own and operate a phar-
- macy - 15
- (c) Physicians known to have financial
- interest in a pharmacy - 40
- (d) Of (c), physicians having a majority
- financial interest - 36
- (e) Total number of physicians - 5740
- (approx.)





(f) Total number of retail pharmacies  
(incl. (b) - 1559

I should point out, of the 36, 33 of these  
pharmacies which have physicians having a majority of  
financial interest, are located in Manitoba.

THE CHAIRMAN: Does that indicate any  
difference in the law in Manitoba?

MR. TURNBULL: No. The law is essentially  
the same sir. There are slight differences. It merely  
indicates a difference, shall we say, in the type of out-  
look by medical practitioners of pharmacy operations in  
that Province.

THE CHAIRMAN: Would these be mostly out-  
lying localities?

MR. TURNBULL: The majority are located in  
the City of Winnipeg.

THE CHAIRMAN: Right in the city? I could  
understand it more readily in an outlying community where  
the doctor has some drugs available but might have diffi-  
culty in getting a pharmacist within reach.

The foregoing figures are presented merely  
to indicate the numerical level at which  
busy medical practitioners have seen fit to  
become involved in extensions of practices  
other than those of their primary profes-  
sional concern of diagnosis and treatment.  
Except where local needs dictate, the prin-  
ciple of the joint practice of medicine and  
pharmacy is, in the opinion of both profes-  
sions, considered to be not in the best



1 interest of the patient. Similarly, finan-  
2 cial involvement of a medical practitioner  
3 in a pharmacy or in a manufacturing and/or  
4 distributing company is not viewed favou-  
5 rably and, indeed, has been officially  
6 frowned upon in one instance in Quebec.  
7 The full, legal practice of Pharmacy is  
8 time-consuming in service and record keeping.  
9 It involves a high inventory of a multitude  
10 of drugs and preparations which consume  
11 much space and money if every need of every  
12 patient's diagnosis is to be properly met  
13 and safeguarded.

14 4. Government agencies which actually  
15 dispense drugs (not including those which  
16 just pay for pharmaceutical services) are:  
17 (a) Federal -- Department of National  
18 Defence; Department of Veterans' Affairs;  
19 Department of National Health and Welfare,  
20 (Indian and Northern Health Services, etc.):  
21 Members of the Armed Forces, as part of  
22 their entitlement upon enlistment, are  
23 granted health care services for themselves  
24 and their dependents. Drugs, according to  
25 a limited inventory list of items, are  
26 available from the hospital pharmacy of  
27 military unit.

28 Department of Veterans' Affairs medical  
29 services, extended to war veterans, are pro-  
30 vided for within hospitals and to ambulatory



1 patients. At the close of World War II, the  
2 Department entered into agreements with  
3 practitioners to provide convenient, free  
4 choice-of-practitioner service to its bene-  
5 ficiaries. Pharmaceutical services were  
6 paid for in accordance with price schedules  
7 in most common usage in each province. The  
8 majority of drugs were, however, made  
9 available through centralized sources such  
10 as D.V.A. hospitals and these sources were  
11 gradually expanded. Today, the same basic  
12 distribution system prevails with the  
13 Department making it increasingly necessary  
14 for its beneficiaries to obtain their pres-  
15 cribed drugs from regional sources, while  
16 asking community pharmacies to stand ever-  
17 prepared "to provide emergency and narcotic  
18 prescriptions".

19 I am sure that everyone is aware of what  
20 happened over the weekend where the Department of Veterans'  
21 Affairs providing prescription drugs found that one of  
22 their beneficiaries did not receive these dangerous drugs  
23 and a city-wide search is going on in Toronto to find them  
24 and keep them out of the hands of children.

25 I think that it is pertinent to point out  
26 at this time that it is regrettable that quantities such  
27 as provided to this one individual, undoubtedly quantities  
28 to enable certain savings to be made in the distribution  
29 of the drugs, were made available; with the potential loss  
30 resulting in extreme danger to people who do not know



1 anything about the potentialities of those particular  
2 drugs.

3 MR. FRAWLEY: Were they dispensed by a  
4 Federal agency you say, Mr. Turnbull?

5 MR. TURNBULL: From the newspapers that is  
6 assumed, yes.

7 THE CHAIRMAN: Were they sent to an indivi-  
8 dual for his or her personal use?

9 MR. TURNBULL: That is correct, through  
10 ordinary mail in quite a large quantity, about 25% of  
11 which is to be considered as deadly.

12 THE CHAIRMAN: That would be in the course  
13 of treatment over quite a period of time, would it? It  
14 would be much more than a doctor would usually prescribe?

15 MR. TURNBULL: I think we must assume it  
16 would be much more than would be normally prescribed at  
17 any one time for a patient's use.

18 THE CHAIRMAN: That is what I mean.

19 MR. TURNBULL: The Indian and Northern  
20 Services Branch of the Department of National Health and  
21 Welfare provides certain health services in accordance  
22 with long-standing treaty arrangements. Such services,  
23 while not entering into the realm of statutory obligations,  
24 are also made available to indigent Indians who no longer  
25 reside on reserved lands. These latter are adjudicated  
26 by regional officers who have made provision for local  
27 services. Recently, the federal authorities have sought  
28 to establish common fee-for-service levels and have indi-  
29 cated their interest in a national Prescription Pricing  
30 Guide to be used in paying for pharmaceutical services.



1 However, contractual agreements of this nature are the  
2 prerogative of the provincial associations and, therefore,  
3 the decisions rest with them.

4 (b) Provincial -- In some provinces, there  
5 exist government dispensaries and/or central  
6 sources of certain drugs according to very  
7 limited inventory lists to meet demand  
8 prescriptions required by indigents and wel-  
9 fare patients, particularly as such may be  
10 required for certain chronic conditions.  
11 There are welfare homes for wards, health  
12 department institutions, outpost hospitals,  
13 etc.

14 (c) County -- Similar, but less extensive  
15 services, to foregoing.

16 (d) Municipal -- Area or community health  
17 offices provide immunization services,  
18 including vaccines and anti-toxins, to those  
19 who wish to avail themselves of them. Some  
20 school boards provide the supervisory and  
21 examination services of dentists and nurses  
22 free of charge, and there are instances where  
23 boards have seen fit to sell specially pur-  
24 chased vitamin preparations to students.

25 5. Industrial dispensaries, in addition to  
26 first aid stations -- free and/or subsidized  
27 services are rendered.

28 6. Volunteer health agencies (e.g., Red  
29 Cross)

30 7. Private institutions:





1 (a) Nursing homes

2 (b) Homes for aged

3 Each and every one has costs differing from  
4 those of the retail pharmacist who, as a private practi-  
5 tioner, must also realize a profit to enable him to render  
6 a first-class service to his community. Further, their  
7 published accounting refers to costs of the drugs, only,  
8 not to the rendering of pharmaceutical service as a whole.  
9 Thus, costing relationships are almost impossible to esta-  
10 blish and are, most probably, impractical from a compari-  
11 son viewpoint.

12 THE PHARMACEUTICAL MANUFACTURING INDUSTRY

13 Earlier in this submission, mention was made  
14 of the Association's Section of Industrial Pharmacists  
15 which, formed in 1958, has a present membership exceeding  
16 350 individual pharmacists who maintain registration with  
17 a provincial statutory pharmacy organization and who are  
18 engaged in one field or another of industry. Thus, the  
19 Association, as a professional association, in addition to  
20 its more general obligations in the whole field of Pharmacy  
21 and public health, has a specific interest in industrial  
22 endeavours as such relate to the position of individual  
23 pharmacists therein. Because it is from industry that the  
24 basic tools of the profession are available, the profes-  
25 sion of Pharmacy cannot, in any way, divorce its interests  
26 from matters of specific concern to industrial enterprise.

27 It is not the objective of this submission  
28 to, in any way, attempt to discuss manufacturing pharmacy  
29 except from the viewpoint of individual pharmacy practi-  
30 tioners and their collective expressions of opinion and



1 policy as voiced through the Association.

2 One of the roles played by any national  
3 organization such as the Canadian Pharmaceutical Associa-  
4 tion is to create and maintain a liaison with other orga-  
5 nizations of similar purpose and activity. Such liaison  
6 committees do exist, one of them being with the Canadian  
7 Pharmaceutical Manufacturers' Association which, although  
8 it represents possibly only one-third of all companies  
9 engaged in the production of drugs in Canada, does repre-  
10 sent most, if not all, of the larger firms and is the  
11 only such organization of the ethical drug industry in  
12 our country.

13 THE CHAIRMAN: I do not recall, my memory  
14 may be at fault, I do not recall a statement the Pharma-  
15 ceutical Manufacturers' Association represented only one-  
16 third of the companies. From what source do you get that  
17 information?

18 MR. TURNBULL: I believe it was brought out  
19 in the various pieces of testimony sir that there are 58  
20 companies - I stand corrected - 58 member companies of  
21 the C.P.M.A. at the present time and in the Green Book,  
22 if my memory serves me right, it is indicated in the  
23 neighbourhood of 180 companies purchasing drugs, purcha-  
24 sing or distributing drugs in Canada.

25 THE CHAIRMAN: That is the source of your  
26 information?

27 MR. TURNBULL: Yes.

28 Meetings of the C.Ph.A. - C.P.M.A. Liaison  
29 Committee have been held from time to time over the past  
30 five years, I believe three times, such as at times



1 following annual meetings, to discuss resolutions and  
2 recommendations of mutual interest. The Terms of Refe-  
3 rence of this Committee are as follows:

4 Membership - To include the president, vice-president and  
5 executive secretary or legal counsel of the  
6 Canadian Pharmaceutical Association and the  
7 Canadian Pharmaceutical Manufacturers' Asso-  
8 ciation.

9 Officers - Both association presidents to serve as  
10 joint chairmen. No other officers are to be  
11 appointed. In the event that a president is  
12 unable to attend a meeting, he shall have the  
13 power to appoint a committee member as his  
14 alternate.

15 Meetings - Places, dates and times to be determined by  
16 the committee members.

17  
18  
19 -  
20  
21  
22 -  
23  
24  
25 -  
26  
27  
28 -  
29  
30



1 Agenda - Each association to prepare its own agenda  
2 for each meeting and to forward a copy of the  
3 agenda to the other association prior to the  
4 meeting.

5 Points of Reference - (1) This committee is formed to  
6 discuss and resolve problems of mutual  
7 interest to both associations. (2) This  
8 committee does not have the power of final  
9 decision, but must refer recommendations to  
10 the respective associations for approval.  
11 (3) This committee shall not discuss, in any  
12 manner whatsoever, matters pertaining to  
13 prices or discounts, or any other matter  
14 which might lead to action in violation of  
15 the provisions of the Combines Investigation  
16 Act or of the Criminal Code or of any other  
17 law of the Dominion of Canada or of any of  
18 the Provinces.

19 Specific mention of matters discussed by the  
20 Association with the manufacturers' group will add nothing  
21 to this Brief. Topics include mutual interest problems  
22 such as: (1) A policy relative to fire-damaged merchandise;  
23 (2) Exemption of drugs from taxation; (3) Drug legislation  
24 and amendments; (4) Labelling, dating, symbols; etc.

25 Pricing Policies:

26 The distribution and pricing situations out-  
27 lined in the Director's Statement (the 'Green Book') are  
28 not new to the Canadian Pharmaceutical Association. The  
29 problem of multiple levels of pricing and price discount  
30 policies as such relate to the various purchasing levels,



1 namely, governments, government institutions, hospitals  
2 and retail pharmacists, is recognized as being of vital  
3 interest to the Canadian consumer who must be assured of  
4 a high level of consumer distribution of pharmaceuticals  
5 by pharmacists in the widespread communities of this  
6 nation. It was recognized by the C.Ph.A. many years ago  
7 that eventually the problem known to them would become  
8 subject to public criticism and would possibly be voiced  
9 with a great deal of misunderstanding.

10 The situation has not changed over the years  
11 to cause any alteration in a statement of policy made  
12 known to manufacturers early in 1955, and which has been  
13 reaffirmed by pronouncements up to, and including the  
14 present time --- "the Canadian Pharmaceutical Association  
15 is of the opinion that the principle of equal price for  
16 equal quantity and equal quality, provided that there is  
17 a reasonable and equitable relationship between quantity  
18 price levels, is the only principle which should guide  
19 pricing policies in the distribution of drugs to all pur-  
20 chasing levels".

21 THE CHAIRMAN: I was wondering, Mr. Turnbull,  
22 if the reasonable and equitable relationship between quan-  
23 tity price levels could be spelled out at all?

24 MR. TURNBULL: Well, I think the best way  
25 would be to indicate by a very non-specific example, sir.  
26 We believe the price of 100, 5,000 and 50,000 should bear  
27 a relative relationship between the quantities concerned  
28 without the 100 price - it might be easier to say without  
29 the 50,000 price so significantly low that it bears abso-  
30 lutely no reasonable relationship to the smaller quantity





1 price.

2 THE CHAIRMAN: A large quantity would sell  
3 at a lower price?

4 MR. TURNBULL: Yes.

5 THE CHAIRMAN: Proportionately. If you  
6 have that reasonable and equitable relationship would  
7 that mean the difference in price would be related to the  
8 cost saving?

9 MR. TURNBULL: Related to cost saving.

10 THE CHAIRMAN: Of the manufacturer and  
11 distributor going to the same class of purchaser, the  
12 price would be the same less an allowance pro-rated reaso-  
13 nably to cost saving?

14 MR. TURNBULL: Yes.

15 THE CHAIRMAN: For a much larger order?

16 MR. TURNBULL: That is correct.

17 This statement is made in the firm belief  
18 that a policy of fair and equitable pricing should be, and  
19 can be established to the satisfaction of manufacturers,  
20 government buyers, hospitals, retail pharmacists and, of  
21 great importance, to the satisfaction of the consuming  
22 public. In consideration of quality, quantity and packa-  
23 ging, a policy of one fair price to all buyers should be  
24 available.

25 Actual prices do not enter into the state-  
26 ment quoted above. Prices and pricing methods relate to  
27 the specific operation of the individual company and/or its  
28 distributors. Presumably, each has the ability to deter-  
29 mine for itself the financial return it requires to provide  
30 for its expenditures and to give remuneration for its



1 efforts in accordance with the product or products it  
2 makes available. Each firm undoubtedly has established  
3 price-calculation policies in keeping with its known  
4 risks, its future aspirations and its marketing integrity.

5           Manufacturers' profits, too, are not a  
6 subject of deliberation on the part of pharmacy practi-  
7 tioners. It is obvious, in any industry, that the ability  
8 to make a profit varies greatly between companies.

9 Profits may bear a relationship to the enterprising  
10 nature of a company. In the pharmaceutical industry, it  
11 would appear that successful enterprise is directly  
12 related to fortuitous research activities, efficient  
13 production and competent promotion and distribution. The  
14 latter two are common business endeavours within the capa-  
15 bility of most, while the first -- research -- is an acti-  
16 vity of interest only to those who are leaders and who  
17 wish to retain their leadership.

18 Research:

19           Research is a subject which is little under-  
20 stood by many. Researching in the field of pharmacy is a  
21 continuing process taking place in the libraries and labo-  
22 ratories of our ultra modern cities, as well as in centres  
23 of less advanced nations. Initial research means little  
24 unless it is such that it may be channeled into a broad  
25 program which establishes therapeutic values and leads to  
26 convenient stable dosage formulations of known pharmacology  
27 and toxicology.

28           The manufacturer who is engaged in research  
29 works with government agencies to establish marketing  
30 approval of new drugs. He brings forth his discovery's



1 chemical make-up and its common name and assists in its  
2 adjudication as a prescription-only item or as one which  
3 need not be so restricted. He establishes, through small-  
4 scale pilot production, methods of quality and quantity  
5 control, assay procedures, manufacturing phase inspections,  
6 aseptic requirements, and the multitude of other matters  
7 which represent 'unknowns' until the newly discovered pro-  
8 duct becomes an established entity.

9           Practising pharmacists have a great aware-  
10 ness of these multiple factors which are part of a product's  
11 availability. Physicians and research pharmacists join  
12 forces in evaluating new drugs before their release and  
13 hence the professions turn naturally to the products of  
14 those companies which are known to devote themselves to  
15 research projects. Too, they turn to those of established  
16 reputation; those which do not content themselves with mere  
17 minimum standards; those of known experience and integrity  
18 which, in the words of one slogan, is termed "the priceless  
19 ingredient".

20           Research may be of several kinds, (a) initial  
21 or academic, (b) specific or project type, (c) application  
22 and developmental, (d) formulation or alteration, (e) pro-  
23 duction or control, and etc. Huge expenditures are made on  
24 all fields and it is interesting to observe, from Table XXV  
25 presented in the Director's Statement, page 124, that funds  
26 made available by commercial firms for medical research in  
27 Canada are exceeded only by those available from our Federal  
28 Government, although there is no indication as to what pro-  
29 portion of the latter expenditure represents drug research.

30           THE CHAIRMAN: Mr. Turnbull, in the Green



1 Book and some other documents we have seen there has been  
2 reference to a type of research called patent research.  
3 Do you have any comments to make on that?

4 MR. TURNBULL: No, I am sorry, sir, I am  
5 not aware of the various ins and outs of that.

6 THE CHAIRMAN: You listed a number of types  
7 so I thought I would ask you about it, if it is a kind  
8 of research.

9 MR. TURNBULL: Canadian Pharmacy recognizes  
10 that up to the present time, drug research being carried  
11 out in Canada has been relatively limited in extent. It  
12 acknowledges, however, that the sale of drugs by companies  
13 in Canada which are subsidiaries of research companies in  
14 foreign lands does contribute to the research budget of  
15 those companies. This is not viewed as a satisfactory  
16 situation, even though it is acknowledged that the econo-  
17 mics of researching often dictate something less than  
18 widespread decentralization of physical facilities.

19 Canada has lost many excellent research  
20 pharmacists who have had to 'seek their fortunes' in other  
21 lands where research and primary manufacturing is well  
22 established. This is most undesirable from Pharmacy's  
23 viewpoint. The development of a pharmaceutical industry  
24 in Canada, be it wholly Canadian-owned or otherwise,  
25 merits encouragement as our population and economy expand,  
26 and would be vital to our nation in the event of a national  
27 emergency.

28 THE CHAIRMAN: Would your Association take  
29 the position that it would be better for Canada if all  
30 pharmaceutical research of drugs which came in use in



1 Canada was made in Canada or is that going too far?

2 MR. TURNBULL: Would it be better if all  
3 pharmaceutical research was carried on in Canada? I  
4 don't think we could be so specific, sir, in that we know  
5 researching being carried on in other countries is of  
6 great benefit to Canadians. We do feel that we would like  
7 to see an expansion of research in the manufacturing phar-  
8 macy in Canada.

9 THE CHAIRMAN: Your position is it would be  
10 better for Canada and for the pharmaceutical industry if  
11 primary research and developmental research were both  
12 carried on much more widely than is now the case?

13 MR. TURNBULL: On a much wider scale.

14 THE CHAIRMAN: Would this be a correct  
15 interpretation of your position: you would regard the  
16 total benefit of research as really being a world-wide  
17 activity from which all benefit?

18 MR. TURNBULL: Yes sir.

19 Quality and Quality Control:

20 The use of batch numbers, datings, storage  
21 instructions, etc., on manufacturers' labels permits a  
22 high degree of control over their products. To such infor-  
23 mation the pharmacist adds his own knowledge of minimum  
24 requirements and standards, physical qualities and chemi-  
25 cal potentials to assist him with his handling of a parti-  
26 cular drug preparation. However, he and the physicians of  
27 his community seldom have any way of knowing, or of esta-  
28 blishing the full extent of the quality of the product  
29 other than through the established reputation of the manu-  
30 facturer.





1 Quantitative analysis -- usually beyond the  
2 scope of the individual pharmacist in private or institu-  
3 tional practice, due to its expense and the time and  
4 equipment necessary -- of the finished product does not,  
5 by itself, necessarily establish all pertinent aspects of  
6 quality. An assurance of quality control in all steps of  
7 production, from the raw product to the finished dosage  
8 form, should be the right of every patient, whether ambu-  
9 latory or hospitalized, who, quite correctly, expects to  
10 receive nothing but the best to alleviate his illness.  
11 Here again, practitioners who render health services, turn  
12 to the products of manufacturers known to them to be  
13 inherently reliable, regardless of their 'bigness' in the  
14 industry. Quality infers pharmaceutical excellence;  
15 control is the means by which excellence is achieved.

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/JW/hm

1 The Canadian Pharmaceutical Association  
2 has commended recently proposed changes to the Regulations  
3 of the Food and Drugs Act which will provide for further  
4 safeguards against undesirable manufacturing practices and,  
5 in general, enhance mandatory control procedure. At the  
6 same time, the Association has recommended that the name  
7 of the responsible manufacturer appear on the label of all  
8 drug products in instances where the distributor is not  
9 the responsible manufacturer. In this way, the pharmacist  
10 may have knowledge of levels of quality concerning the  
11 products he uses. A government agency can do much to police  
12 regulations pertaining to manufacturing and manufacturing  
13 control. It cannot, nor should it be expected to attest  
14 to each and every batch of drug which is placed on the  
15 market. This is the responsibility of the ethical  
16 manufacturer. That is the dictionary definition of the  
17 term "ethical".

18 THE CHAIRMAN: Just a moment, the dictionary  
19 use of the word "ethical"?

20 MR. TURNBULL: I am sorry, I was not  
21 thinking of the ethical drug definition as contained in  
22 the green book. In this particular instance I am talking  
23 about ethical manufacturers.

24 THE CHAIRMAN: If there are any that are  
25 not ethical, would it still be their responsibility?

26 MR. TURNBULL: I am not inferring that there  
27 are any that are not ethical.

28 THE CHAIRMAN: That they are manufacturers  
29 at all, wouldn't you say it is their responsibility? Isn't  
30 that the position you would take?



1 MR. TURNBULL: Yes.

2 Promotion and Advertising:

3 The Association has, from time to time,  
4 expressed its views concerning promotional methods utilized  
5 by drug manufacturers and distributors. Such views have  
6 not, however, been related to methods which have recently  
7 been suggested as being non-professional, expensive, or  
8 of little value to the practising physician. These latter  
9 suggestions are referred to in the Director's Statement  
10 and have often been brought forth in the question periods  
11 of the Commission's regional hearings. Comment by our  
12 Association would add nothing.

13 The problem of sampling which, on many  
14 occasions, appears to be wasteful and, in some instances,  
15 dangerous, is befitting of our concern. Overly generous  
16 sampling procedures sometimes cause a deterioration in the  
17 relationship between physician and pharmacist, as well  
18 poor public relations with the patient. Samples bearing  
19 original labels given to a patient often result in demands  
20 for repeat medication which cannot be supplied without a  
21 proper prescription. If the demands can be met by pres-  
22 cription or otherwise, the preparation often appears  
23 expensive in the eyes of the patient who initially received  
24 them without charge. This is a public relations problem,  
25 of course.

26 THE CHAIRMAN: I suppose if he charges  
27 anything, it would seem expensive in comparison with getting  
28 it free.

29 MR. TURNBULL: True.

30 The pharmacist's greatest concern relates



1 to the sampling of prescription-only drug items and the  
2 inherent dangers arising from the mishandling of such  
3 samples. They may, for one reason or another, find their  
4 way into the hands of the lay public, or worse, into the  
5 hands of children. Our Association has frequently  
6 recommended "That sampling be done only to those physicians  
7 or institutions who request a quantity of the preparation  
8 for experimental or investigational purposes." The  
9 provision of samples to members of the health professions  
10 is a legal procedure under the Food and Drugs Act.  
11 Unsolicited samples could be voluntarily restricted to  
12 minor quantities sufficient to establish the physical  
13 identity of the preparation referred to in medical informa-  
14 tion pieces which they accompany.

15 THE CHAIRMAN: Can you tell us more about  
16 how seriously you regard that situation? As I understand  
17 it, sampling is made to members of the medical profession.

18 MR. TURNBULL: In the main, sir, yes.

19 THE CHAIRMAN: Do you think there is any  
20 great danger of drugs that are given to members of that  
21 profession as samples being dealt with carelessly?

22 MR. TURNBULL: Yes, I think so. It is less  
23 than two years ago that there was a very serious case  
24 where children apparently got into one of the community  
25 nuisance grounds in the Toronto area and apparently got  
26 their hands on some samples that had been thrown out in  
27 garbage from a doctor's office, and there were rather  
28 serious consequences.

29 I don't have that document, by the way,  
30 but I do recall the small panic at that time. I also know



1 that there are instances where these things have been  
2 found in some quantity in garbage cans, but I could not  
3 tell you the type of sample they are.

4 In talking this way, I would infer, and I  
5 wish to correct it, that none of the samples are used. I  
6 would suggest that what is thrown out are samples that  
7 were of no use to the physician, and he has possibly made  
8 excellent use of other samples offered to him. We know,  
9 too, that samples are used by physicians to help needy  
10 people and that type of thing.

11 THE CHAIRMAN: This matter of the physician  
12 apparently not taking sufficient care how they were  
13 handled, that was raised in this paragraph and I was  
14 wondering how seriously you regarded the situation. You  
15 have given us one or two instances. This is the fact, and  
16 I can see where physicians toss them in the wastebasket  
17 there might be some danger, all right.

18 MR. TURNBULL: A physician is a very busy  
19 man, of course. Quite often he would not get to the point  
20 of possibly reviewing all this material, and I think that  
21 has been brought out in other instances.

22 Many promotional undertakings are attention-  
23 seekers classed by some as being the brainchildren of  
24 hucksters of less sophisticated items. Our Association  
25 is not qualified to comment on these undertakings other  
26 than to indicate that some appear meritorious in that  
27 their sponsors consider them worthy of continuance.  
28 Individually considered, they may appear expensive, but  
29 in relation to an overall budget they, by themselves,  
30 probably represent minor expenses the deletion of which would





1 little affect a drug's price.

2 Far from incidental to a drug's price is the  
3 cost of getting first-hand information about a product to  
4 the physicians and pharmacists in the thousands of wide-  
5 spread communities of our nation. Journal advertising  
6 provides some of the financial means whereby the pro-  
7 fessions may publish articles and papers of interest and value  
8 to practitioners. Direct mail, exceedingly wasteful in  
9 any business and definitely objectionable in saturation  
10 quantities, refreshes memories and, to a certain degree,  
11 provides a point of reference and opinion about the  
12 addressor. Direct contact, through the activities of  
13 field forces of company representatives guided by the  
14 company's medical executives and sales managers, provides  
15 an opportunity for discussion of matters not always  
16 appreciated from the reading of technical papers, amidst  
17 the routine of a busy day. Without a doubt, the medical  
18 detail man is most familiar with the product of his own  
19 company and he emphasizes his company's name and its brand  
20 names, but at the same time, he probably conveys informa-  
21 tion which is available in no other practical form. This  
22 is especially true relative to drug formulations and  
23 particular dosage modifications. The detail man is  
24 usually a pharmacist, but, regrettably, to meet the man-  
25 power needs of this expanded field of endeavour, there is a  
26 relatively small number of men available with these  
27 qualifications.

28 THE CHAIRMAN: That sentence raises a  
29 question. I am wondering if it should not be modified  
30 a little bit. You say the detail man is usually a pharmacist



1 and then you say there is a relatively small number of  
2 men available with these qualifications. Does that mean  
3 that there are only a few detail men?

4 MR. TURNBULL: "There is a relatively small  
5 number of men available with these qualifications". That  
6 is, there is a relatively small number of pharmacists  
7 available to industry for this use as detail representa-  
8 tives.

9 THE CHAIRMAN: Yes, but then you start off  
10 by saying, "A detail man is usually a pharmacist". Are  
11 there very few of them then?

12 MR. TURNBULL: Yes. I see your point.  
13 Rather than attempt to extend it ---

14 THE CHAIRMAN: I am asking that partly  
15 because we have had varying statements made to us about  
16 the qualifications of detail men. We have been told by  
17 some that most are not pharmacists. Some are, some have  
18 partial training as pharmacists, and some have pre-medical  
19 training, and some have very little special training  
20 before they begin to work for the company.

21 MR. TURNBULL: Our experience here is that  
22 possibly if we just change the word "is" to "was", "the  
23 detail man was usually a pharmacist", and to explain it,  
24 that in this greatly expanded field of endeavour, today  
25 there is a relatively small number of these detail men who  
26 are actually pharmacists.

27 THE CHAIRMAN: "Detail man was usually  
28 pharmacist", that would be the days when the companies did  
29 not use so many of them, is that it?

30 MR. TURNBULL: That is correct, and there



1 were not so many companies.

2 THE CHAIRMAN: And now with the greatly  
3 expanded field in which detail men are considered necessary.  
4 Many more are required and a relatively small number of  
5 men are available with these qualifications, so that quite  
6 a large proportion so far as your information goes are not  
7 at least fully qualified pharmacists.

8 MR. TURNBULL: That is correct.

9 Advertising and promotional methods con-  
10 cerning pharmaceutical preparations both sell and educate.  
11 They provide fast and factual new product information about  
12 some 300 to 500 introductions each year. Pharmaceutical  
13 advertising messages must be carefully written to place  
14 the advertiser and his product in the best light, while  
15 holding claims to a minimum, according to self-imposed  
16 restrictions and checks imposed by governments and the  
17 professions.

18 The ethical advertiser promotes himself and  
19 his products without reference to comparisons and the  
20 established prestige of others and the known utility of  
21 the products of others. Pharmaceutical advertising, properly  
22 conducted with an absence of undesirable frills, actually  
23 lowers the cost of drugs by increasing production and  
24 ultimate distribution. Doubt must be cast upon any  
25 expressions of thought that industry might well abandon  
26 expensive promotions and pass the resultant savings on to  
27 the patient --- Without advertising, few of today's in-  
28 valuable medicaments would be known and further, of course,  
29 the similar, possibly less expensive products of non-  
30 advertisers would not exist.



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Turnbull

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II/EMI/hm 1 THE CHAIRMAN: Do you say without advertising  
2 they would not come into existence?  
3 MR. TURNBULL: It is of great assistance.  
4 MR. WHITELEY: Would the advertising increase  
5 production?  
6 MR. TURNBULL: Greater utilization would  
7 require increased production, would it not.  
8 THE CHAIRMAN: You mean similar products, is  
9 that it, similar to those that are being advertised?  
10 MR. TURNBULL: I did not think Mr. Whiteley's  
11 question was directed to that part, was it, sir?  
12 MR. WHITELEY: You make the statement that  
13 pharmaceutical advertising increased production.  
14 MR. TURNBULL: I would add the words  
15 "successful result of pharmaceutical advertising increases  
16 production."  
17 MR. WHITELEY: Have you seen the information  
18 in the Green Book that a massive advertising campaign does  
19 affect the sale of a particular drug?  
20 MR. TURNBULL: I believe that is referred to  
21 some extent in the Green Book yes, sir. The statement is  
22 based on usual business experience, is it not, that  
23 successful advertising would quite naturally increase  
24 production to meet the needs created by the successful  
25 advertising, would it not?  
26 MR. WHITELEY: Some of the evidence we have  
27 received is that the situation in this field differs from  
28 that of the normal consumer market where the advertiser  
29 appeals directly to the purchaser of his product and  
30 brings to the consumer's mind wants which he might not have



1 thought he had.

2                   Some of the evidence we have received is  
3 that the use of the drug only arises when there is the  
4 need in some special form of treatment, and that advertising  
5 does not create the need for this type of treatment..

6                   MR. TURNBULL: No. I think I can agree.  
7 However, in this instance, advertising creates an awareness  
8 of the availability of a treatment for the illness that  
9 has been encountered.

10                  MR. WHITELEY: Would that not lead to lower  
11 production of some other form of treatment?

12                  MR. TURNBULL: Conceivably.

13                  MR. WHITELEY: As a matter of fact, might  
14 it not increase at all?

15                  MR. TURNBULL: You mean in the overall  
16 industry?

17                  MR. WHITELEY: Yes.

18                  MR. TURNBULL: Not in one specific item,  
19 yes.

20                  THE CHAIRMAN: I suppose in some cases where  
21 you get a new drug, you have a treatment for a condition  
22 for which there was no effective treatment at all?

23                  MR. TURNBULL: Well, there would always be  
24 a symptomatic treatment whether it was a specific disease  
25 treatment. There has always been symptomatic treatment  
26 in any event.

27                  MR. WHITELEY: It seems to me the question  
28 is the way medical knowledge is obtained, one would assume  
29 that is a spread of medical knowledge rather than adverti-  
30 sing of particular products, the use of a particular drug.





1 In other words, a doctor does not use a drug because it  
2 is advertised; he uses it because he knows that that drug  
3 will meet a particular requirement that he has.

4 MR. TURNBULL: Yes, sir. I do not believe  
5 that I am fully qualified to speak on this. My mind takes  
6 me back to the presentation of Mr. Thompson of Cyanamid  
7 when he was discussing the promotion of a specific item  
8 for use within a specific disease category, and the amount  
9 of advertising that may be required relative to the  
10 company's specific product, in addition to the medical  
11 literature and medical publications that had already made it  
12 known. I believe he was talking about one or two products  
13 that he had as samples.

14 MR. WHITELEY: I think in some cases just  
15 the notice of this did not lead to any real demand for  
16 them.

17 MR. TURNBULL: That is correct, yes.

18 THE CHAIRMAN: It is a question of ---

19 MR. TURNBULL: Of relative success.

20 THE CHAIRMAN: It is a question of the  
21 influence the advertising has on the mind of the physician  
22 ultimately who writes the prescription.

23 You are now coming to patents -- I don't  
24 think there is very much there -- and brand names and  
25 generic designations. The Green Book deals with that at  
26 length. I might suspect that these are sections where  
27 there may be some questions, and perhaps we had better  
28 adjourn until tomorrow morning before we embark on  
29 something that will take some time to get over. Perhaps  
30



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1 we had better adjourn until tomorrow morning.

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3 ---Whereupon the hearing ajourned until 10 a.m.

4 Tuesday, October 24th, 1961.

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3 INQUIRY UNDER SECTION 42  
4 OF THE COMBINES INVESTIGATION ACT  
5

6 Relating to the manufacture, distribution and sale  
7 of drugs  
8

9 By Director of Investigation and Research  
10 Combines Investigation Act  
11

12 COMMISSION:

13 C. RHODES SMITH, Q.C. -- Chairman  
14 A.S. WHITELEY, M.A. Member of the  
15 Commission  
16 PIERRE CARIGNAN, Q.C. Member of the  
17 Commission  
18 F.N. MACLEOD Combines Officer,  
19 representing the Director of Investigation and  
20 Research  
21

22 Proceedings of hearings commencing at  
23 10.00 a.m., Tuesday, October 24th, 1961,  
24 et seq in the City of Toronto, in the  
25 Province of Ontario.  
26  
27  
28  
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Toronto, Ontario,  
October 24th, 1961.

1  
2  
3 ---On commencing at 10.00 a.m.

4 THE CHAIRMAN: Mr. Turnbull?

5 MR. TURNBULL: Mr. Chairman, and members  
6 of the Commission, starting at the section dealing with  
7 patents, page 37 of our presentation:

8 PATENTS

9 Canadian patent legislation does not sub-  
10 ordinate patent rights of an inventory except where there  
11 is evidence of (a) non-use of the patent; (b) the need to  
12 facilitate the use of improvements or depending patents;  
13 (c) a need to alleviate specific abuses of patents; (d)  
14 questions concerning public good and welfare; (e) instances  
15 where a patent has been used to restrain or injure trade.  
16 Jointly, these pertain to patents related to food and to  
17 drugs where patents may only be issued for the process or  
18 the product when produced by a specific process.

19 THE CHAIRMAN: You are not referring in those  
20 things to the compulsory licence?

21 MR. TURNBULL: No sir.

22 The 'inventor' of a drug is entitled to patent  
23 protection under Canadian laws, provided the usable end  
24 product(s) of his invention is freely available to meet  
25 the needs of Canadians. Barring the existence of the above  
26 quoted conditions which may cause rights to be subordinated,  
27 patent protection should extend to the drug regardless of  
28 its country of origin, and provided also, that in due  
29 course, but not exceeding a period of three years or other  
30 suitable period made necessary by the nature of the drug,





1 it should be produced in Canadian-based manufacturing  
2 facilities. As at the present, the patent holder should  
3 have the right to license other producers. Compulsory  
4 licensing provisions of the Patent Act should continue to  
5 be exercised to facilitate legal production by Canadian  
6 companies.

7 THE CHAIRMAN: Mr. Turnbull, you understand  
8 that of course the compulsory licensing provisions of the  
9 Patent Act mean that a licence can be obtained against  
10 the wishes of the patentee, in other circumstances  
11 than those outlined in your first paragraph?

12 MR. TURNBULL: That is understood sir.

13 THE CHAIRMAN: Your views are then that the  
14 licensing, the present compulsory licensing provisions  
15 should continue? You are not proposing any change in those  
16 at all?

17 MR. TURNBULL: No, we are not proposing  
18 any change. Possibly our reference here, to facilitate,  
19 could be explained. There has been some indications in  
20 representations to the Commission that one of the diffi-  
21 culties has been certain delays in obtaining compulsory  
22 licensing and hence there is some objection to the way in  
23 which it has been -- the Act has been administered.

24 However, at the same time I think that we  
25 all realize that the very fact that there is a compulsory  
26 licensing provision has influenced to some degree the  
27 voluntary giving of licensing privileges by the inventor  
28 or his company representative to other companies to  
29 produce the drug.

30 We do not feel that there is any necessary



1 change, but if these allegations of delays and hardship  
2 in getting the licence are true, possibly the administra-  
3 tive end should be looked at a little bit.

4 THE CHAIRMAN: We have had suggestions, or  
5 recommendations, as you will recall going both ways as far  
6 as compulsory licensing is concerned. The proposal is  
7 that the compulsory licensing provisions should be  
8 abolished and the proposal, on the other hand, that it  
9 should be made operative immediately the patent is obtained.

10 Now I take it that as far as your Association  
11 is concerned you are not taking any position with regard  
12 to any change?

13 MR. TURNBULL: That is correct.

14 THE CHAIRMAN: You are satisfied with the  
15 rules as they now stand. Then the question arises: Do  
16 you feel, or does your Association feel that the compulsory  
17 licensing provisions affect the work of the retail  
18 pharmacist at all?

19 MR. TURNBULL: No, I do not believe there  
20 is any direct relationship there, or any direct effect.  
21 Possibly indirect but I cannot think of any circumstance  
22 at the moment sir.

23 THE CHAIRMAN: Then I take it your recommenda-  
24 tion is that the compulsory licensing provisions remain  
25 on the Statute Books, be not altered, based on your view  
26 that it is a good thing for the public?

27 MR. TURNBULL: Generally, yes.

28 BRAND NAMES AND GENERIC DESIGNATIONS

29 Previous sections of this brief have recounted  
30 certain highlights in pharmaceutical history. At the turn



1 of the century, prescribed drugs were, in the main, official  
2 drugs or combinations thereof in recognized formulation  
3 or in formulae written for extemporaneous compounding. The  
4 pharmacist stocked a relatively small number of vegetable  
5 drugs and chemical substances for compounding into mixtures,  
6 ointments, lotions, liniments, etc. Some fluid extracts,  
7 tinctures, syrups, pills and liniments, as described in  
8 official reference books, were in popular use.

9                   In Europe and the U.S.A. standardized pre-  
10 parations marketed by mass-producing companies were found  
11 to have advantages by providing a minimum of variation  
12 in potency from batch to batch. Formulations became  
13 distinctive and thus the "pharmaceutical specialty" had  
14 its origin. Easy-to-recognize brand names became known but  
15 were accepted with reluctance on the part of the pharmacist  
16 because of their intrusion into his private domain and  
17 because he resented the substantial increase in inventory.

18                   The German chemical industry brought  
19 Aspirin, Luminal, Novocain, Salvarsan and other synthetic  
20 medicinal chemicals which were successfully duplicated  
21 by other nations during World War I. Hence, to the "brand  
22 name pharmaceutical" was added the "brand name medical  
23 specialty".

24                   THE CHAIRMAN: All four of these drugs you  
25 mention are trade names?

26                   MR. TURNBULL: They are all trade names,  
27 correct.

28                   A further development which provided a very  
29 significant impetus to the popularity of these new drugs  
30 was the development of the compressed tablet as a dosage



1 form. Providing exact dosage, even for minute doses, and  
2 lending itself readily to mass-production, the tablet  
3 soon became the predominant dosage form. Thus, the move  
4 away from mixtures compounded by the individual pharmacist  
5 to today's formulations prepared under the advantages of a  
6 well-equipped plant, with exacting supervisory methods, has  
7 resulted in a new concept of prescription writing --- the  
8 specifications of a "brand name drug", which identifies  
9 the drug and its manufacturer. While the prescriber may,  
10 in the first instance, make his selection of a specific  
11 brand on the basis of good will and a regard for the  
12 reputation of its manufacturer, the responsibility is his,  
13 none the less, to arrive at a practical evaluation of that  
14 product by observation of the therapeutic result he  
15 obtains with it. In the absence of evidence to the  
16 contrary, the pharmacist must assume the physician's choice  
17 is made on the basis of a preference for the brand indicated  
18 and it has become axiomatic that no deviation be made from  
19 the physician's instructions without his knowledge and  
20 express consent.

21 THE CHAIRMAN: Mr. Turnbull, perhaps that  
22 leads to a question. You have heard the proposal which  
23 has been made in Alberta which has been mentioned by Mr.  
24 Frawley that except where the physician expressly states  
25 that a particular brand name is to be used, the pharmacist  
26 is given the right to interchange drugs which are similar,  
27 though from what we have been told this last week, not  
28 exactly identical. What are the views of your Association  
29 on a proposal of that kind? Or have you formed any?

30 MR. TURNBULL: May I answer that in about



1 two pages' time sir?

2 THE CHAIRMAN: Oh, you are coming to that?

3 MR. TURNBULL: I may not answer that  
4 specifically, but I believe that our statement in that  
5 regard might cover the situation.

6 THE CHAIRMAN: I do not recall you saying  
7 anything dealing with that particular question.

8 MR. TURNBULL: I have not. I will indicate  
9 it at that time, if you wish to stop me at that time.

10 MR. COOK: What page?

11 MR. TURNBULL: Page 40, approximately the  
12 middle of the page.

13 A great majority of the new drugs are  
14 chemical entities and can be identified by standard  
15 chemical nomenclature. The chemical name, however, is  
16 usually too unwieldy for everyday use. Consequently, it  
17 is the usual practice now to provide them with non-  
18 proprietary or common names (now usually designated as  
19 "generic" names). One of the chief purposes of the non-  
20 proprietary name is to provide a name common to all pro-  
21 ducers of the drug for the purpose of identification and  
22 by which it can be designated in the scientific literature  
23 of the various countries. Indeed, machinery now exists  
24 through the World Health Organization for the purpose of  
25 systematizing the choice and approval of generic names on  
26 an international basis. Thus, the identification of a  
27 drug by a generic name is not inconsistent with the fact  
28 that it may also be marketed under a brand name. The  
29 manufacturer, or distributor, who does not choose to  
30 further identify himself with the product by using a brand





1 name must still connect himself with the product by placing  
2 his firm's name on the label as the law requires.

3                   The Canadian Pharmaceutical Association, as  
4 an association, has not entered into the controversy  
5 respecting brand names and non-brand names, other than with  
6 respect to their handling and distribution by the  
7 practising pharmacist. The Association does not subscribe  
8 to nor accept the thesis that drugs with the same generic  
9 name, with or without an added brand name, are necessarily  
10 therapeutic equivalents. Our views on this subject are  
11 borne out by an article, entitled, "Pharmaceutical  
12 Formulation and Therapeutic Efficiency" in the Journal  
13 of the American Medical Association, Volume 177, No. 10,  
14 September 9, 1961, the preface summarization of which reads:  
15 "Formulation of drugs into various dosage forms may modify  
16 profoundly the onset, intensity, and duration of physiolo-  
17 gical response, the correct dosage for the patient, the  
18 incidence and intensity of side effects, and the stability  
19 of the drugs. These effects are illustrated by examples  
20 from the clinical and scientific literature. Because  
21 of the modifications discussed, it is clear that in some  
22 cases choice of dosage form and manufacturer's brand may  
23 be as important as choice of the actual therapeutic agent."

24                   Mr. Chairman, with your permission I would  
25 like to present a reprint, or at least a photographic  
26 copy of this article as an exhibit.

27  
28 ---EXHIBIT T-15

Article entitled Pharmaceutical  
Formulation and Therapeutic  
Efficiency, published in the  
Journal of the American Medical  
Association, Sept. 9, 1961.



/dpw

1 MR. WHITELEY: Mr. Turnbull, does this point  
2 refer to the one which was raised yesterday that a diffe-  
3 rent formulation in the base such as between water soluble  
4 and petroleum base would be a different product in the  
5 eyes of the pharmacist?

6 MR. TURNBULL: It refers to that point, yes  
7 sir. That is one of the matters brought out in this. I  
8 believe the example used yesterday and on a previous occa-  
9 sion has been related to an ointment base, an oil base,  
10 oil soluble base as opposed to a water soluble base,  
11 washable grease base. It also happens in instances of  
12 tablet disintegration, the type of excipient or binder  
13 used in the preparation of the tablet or type of coating  
14 that is placed on the tablet, be it a normal one time  
15 coating or a time disintegration coating. This particular  
16 article, you will realise was released on September 9th,  
17 1961 so it hasn't been in our hands very long. We felt  
18 it was bringing out these points most dramatically in that  
19 it is a study of two prominent educators in the United  
20 States writing in the American Medical Association Journal.  
21 There is a good reference in here. With your permission  
22 I would read a brief paragraph, Mr. Chairman, concerning  
23 just a change in dosage and nothing else in the dosage  
24 format. It was suddenly found by the producing company  
25 to lack what they thought was going to be achieved by  
26 changing the formation of the tablet and strengthening it.  
27 I refer you to the third paragraph:

28 "A dramatic example illustrating differences  
29 in intensity of action of a drug as a result of dosage  
30 form modification has been given by Lozinski. His company



1 found it desirable to increase the physical size of their  
2 bishydroxycoumarin (Dicumarol) tablets to facilitate  
3 breaking the tablets for administration of half doses.  
4 Patients who switched from the smaller to the new larger  
5 tablets required larger doses in order to maintain proth-  
6 rombin levels in the therapeutic range. Laboratory  
7 studies undertaken to explain this difference indicated  
8 that the dissolution rate of drug from the large tablets  
9 was slower than from the old tablets. The tablets were  
10 reformulated to increase this rate, and these were then  
11 used to replace the stocks of older tablets in retail and  
12 hospital pharmacies. A surprising turn of events occurred.  
13 It became apparent that some patients who had their pres-  
14 criptions refilled with the newest tablets showed proth-  
15 rombin levels below the therapeutic range and, in some,  
16 bleeding occurred. The company alerted all physicians  
17 concerning the more intense therapeutic effect of the new  
18 bishydroxycoumarin tablets and urged that all patients on  
19 anticoagulant therapy with their brand of bishydroxycou-  
20 marin tablets be retitrated for their requirements. It is  
21 quite likely that no 2 manufacturers' brands of bishydroxy-  
22 coumarin tablets will act alike in therapeutics, and it is  
23 conceivable that a change from a slow release brand to a  
24 fast release brand might even result in death if the  
25 necessity for retitration is not recognized."

26 I point that up as an example of the basic  
27 fact that a quantitative analysis of these tablets would have  
28 determined that one has such-and-such a quantity of  
29 this active ingredient and the other had a double quantity  
30 of an active ingredient to facilitate and was facilitating



1 dosage.

2 THE CHAIRMAN: Even though these were being  
3 made by one company, making its own dosage form, when  
4 they were made larger does that mean some additional  
5 filler of some kind without any change in the quantity  
6 of the therapeutic action?

7 MR. TURNBULL: That is correct, possibly a  
8 different type, quite a different type of filler or, on  
9 the other hand, a difference in ratio between the filler  
10 and the active ingredient in the formulation of the tablet  
11 prior to punching in the tablet machine. This is the  
12 critical part in tableting, the actual binder and all  
13 that is used in the formulation prior - in the prepara-  
14 tion prior to being put through the punching machine.

15 THE CHAIRMAN: If you have more filler and  
16 leave the therapeutic action, the relation between that  
17 and the quantity is changed and they are mixed, that  
18 might lead to some different rate of the action when the  
19 tablet is taken?

20 MR. TURNBULL: I stand corrected, sir, on  
21 this, it is not in this particular article, but  
22 I also understand this company in one of its formulations  
23 of a different dosage used a different size screen in  
24 preparation of their active ingredient and it was suddenly  
25 found the slightly larger-sized particle of the active  
26 ingredient wasn't doing the job. In a greater part of  
27 this whole study this was actually what happened.

28 THE CHAIRMAN: Different size crystals?

29 MR. TURNBULL: A particle rather than a  
30 crystal.



1 THE CHAIRMAN: They would dissolve at a  
2 different rate, I suppose?

3 MR. TURNBULL: Yes.

4 THE CHAIRMAN: One other question occurred  
5 to me in connection with your paragraph on page 39, "For-  
6 mulation of drugs into various dosage forms may modify..."  
7 That doesn't apply simply to tablets, does it?

8 MR. TURNBULL: Capsules, liquids.

9 THE CHAIRMAN: Injectables?

10 MR. TURNBULL: Ointments, injectables,  
11 most definitely.

12 THE CHAIRMAN: All types, that is what I  
13 was thinking?

14 MR. TURNBULL: Yes.

15 THE CHAIRMAN: From my limited knowledge,  
16 I have read that injectables sometimes get quicker, more  
17 effective action than something taken orally although  
18 something taken orally may have a better long-range reac-  
19 tion.

20 MR. TURNBULL: Your injectables are based,  
21 time based to provide for continued relief.

22 THE CHAIRMAN: There is a difference in  
23 the physiological results when taken a different way,  
24 an injectable goes right into the bloodstream?

25 MR. TURNBULL: It is immediately available  
26 to the bloodstream.

27 THE CHAIRMAN: Taken orally it has to pass  
28 through other channels before it gets there and sometimes  
29 changes have occurred before it gets there?

30 MR. TURNBULL: Yes.





1 MR. WHITELEY: Is there any criterion which  
2 distinguishes between those products such as the one  
3 referred to yesterday that the pharmacist wouldn't regard  
4 as being the same and those preparations which he would  
5 regard as being in the same class?

6 MR. TURNBULL: It would be a very difficult  
7 thing to answer you fully on that, Mr. Whiteley, in that  
8 the criterion would definitely be different for different  
9 preparations. The first criterion or first thing that a  
10 practising pharmacist would look for would be what we call  
11 degree of pharmaceutical excellence in the preparation of  
12 the tablet or capsule and what have you, whether the tablet  
13 even in the bottle as received has stood up over the  
14 journey to the store, whether there is any evidence of  
15 discolouring in the tablet or the capsule.

16 MR. WHITELEY: You are referring to things  
17 you would actually see?

18 MR. TURNBULL: Physical attributes of the  
19 preparation.

20 MR. WHITELEY: I was referring to the distinc-  
21 tion that was made yesterday, a product of a different  
22 base wouldn't be regarded as the same, it wouldn't be a  
23 question of taking one or the other. You would have one  
24 different.

25 MR. TURNBULL: There would be no question  
26 they are different products.

27 MR. WHITELEY: If you have the different  
28 dosage form you would have a difference.

29 MR. TURNBULL: Basically that is a different  
30 product as well.



1 MR. WHITELEY: I was wondering whether you  
2 could, is there any line where you could say - this  
3 clearly wouldn't be the same product. On the other side  
4 they might be roughly the same product.

5 MR. TURNBULL: Just from his study of the  
6 literature and his knowledge and ability to understand  
7 the literature, from his own knowledge of what he himself  
8 expects to find in the physical part of the preparation  
9 and possibly from his experience with products of a  
10 similar nature or the experience of his prescribing for  
11 physicians he is serving in his community.

12 MR. WHITELEY: Take the difference in tablet  
13 size, would that be sufficient to distinguish two products  
14 even though they have the same chemical ingredient?

15 MR. TURNBULL: It would definitely distin-  
16 guish two products. It wouldn't necessarily say the two  
17 tablets didn't contain the same quantitative amounts of  
18 the active ingredient.

19 MR. WHITELEY: Assume they did contain the  
20 same amount but they differed in size.

21 MR. TURNBULL: Yes.

22 MR. WHITELEY: Would that be a sufficient  
23 difference to say these two products wouldn't be taken  
24 one for the other?

25 MR. TURNBULL: They are two different  
26 products, they are the products of two different manufac-  
27 turers, I presume you mean.

28 MR. WHITELEY: Yes.

29 MR. TURNBULL: As we say they may or they  
30 may not be identical in quality and quantity and



1 therapeutic activity.

2 MR. WHITELEY: Assuming they are the same  
3 in quantity of the active ingredient.

4 MR. TURNBULL: But the difference of size  
5 of the tablet has no bearing on the therapeutic action of  
6 the tablet itself.

7 MR. WHITELEY: You say it would have in  
8 effect?

9 MR. TURNBULL: This was using an example  
10 where it was found increasing the dosage and doubling the  
11 dosage had a less therapeutic effect than had been antici-  
12 pated with a double dose.

13 MR. WHITELEY: I thought the size of the  
14 tablet regardless of the dosage had a bearing?

2 15 MR. TURNBULL: No, no, I am trying to think  
16 of an example. In many instances it is possible to  
17 put a dose - four times the dose in the same size tablet  
18 because of the manner in which it must be prepared, the  
19 same tablet could conceivably contain up to four or five  
20 times the dosage.

21 MR. WHITELEY: From what you have said any  
22 difference in the amount would clearly distinguish one  
23 product from the other, there would be no question?

24 MR. TURNBULL: Not physical appearance,  
25 it would be based on the experience of the therapeutic  
26 action.

27 MR. WHITELEY: The amount of ingredient  
28 in the tablet would distinguish one product from another?

29 MR. TURNBULL: Not necessarily. In thera-  
30 peutic action, yes, not physical appearance.



1 MR. WHITELEY: I mean, if a druggist is  
2 faced with filling a prescription.

3 MR. TURNBULL: Yes.

4 MR. WHITELEY: And so given the option of  
5 selecting the manufacturer.

6 MR. TURNBULL: Yes.

7 MR. WHITELEY: If there was a difference in  
8 the amount of ingredients in the tablet you would regard  
9 that as a sufficient factor to select one and not the  
10 other?

11 MR. TURNBULL: The prescription is written  
12 for a 5-milligram tablet. The pharmacist is instructed  
13 to use his discretion in the dispensing of a tablet which  
14 will meet the needs of the physician's prescription, so  
15 he will dispense only a tablet which to his knowledge,  
16 based on the label and his confidence that the label  
17 dosage is actually a 5-milligram tablet, he will dispense  
18 a tablet which contains 5 milligrams of that active ingre-  
19 dient and the one in which he feels that he has the greatest  
20 confidence.

21 MR. WHITELEY: You wouldn't change and put  
22 two 2½-grain tablets?

23 MR. TURNBULL: Not necessarily, if the 5-  
24 milligram wasn't available that would be a different  
25 situation. If only the half dosage size was available  
26 undoubtedly he would refer that to his physician because,  
27 in the first place, the physician has probably told the  
28 patient, now get this filled and take one three times a  
29 day. She is not going to have very much confidence if she  
30 gets a prescription filled and the label suddenly reads



4/nm

1 take two,three times a day?

MR. WHITELEY: Yes.

2 MR. TURNBULL: This is going to be explained  
3 both to the physician and the patient.

4 THE CHAIRMAN: In this actual paragraph  
5 that you are reading, Mr. Turnbull, I thought there was  
6 a distinction based on the size in the example, and I am  
7 a little bit puzzled. It says:

8 "Patients who switched from the smaller to  
9 the new larger tablets required larger doses  
10 in order to maintain prothrombin levels in the  
11 therapeutic range. Laboratory studies under-  
12 taken to explain this difference indicated  
13 that the dissolution rate of drug from the  
14 large tablets was slower than from the old  
15 tablets."

16 If increasing the size of the tablet means the dissolution  
17 rate was slower, would that not have any effect on the  
18 drugs?

19 MR. TURNBULL: Most definitely it is  
20 indicated in here, yes.

21 THE CHAIRMAN: So increasing the size of  
22 the tablet did affect the use of the drug?

23 MR. TURNBULL: Yes.

24 THE CHAIRMAN: Sometimes mere size  
25 apparently has an effect.

26 MR. TURNBULL: Yes. Mr. Chairman, possibly  
27 Dean Matthews might wish to add something here for a point  
28 of clarification, if you wish, at this time.

29 THE CHAIRMAN: If Dean Matthews has some-  
30 thing, we would be glad to have it.





1 DEAN MATTHEWS: I think perhaps I might  
2 cast a little light on Mr. Whiteley's question. He asked  
3 Mr. Turnbull whether there was any criterion for compari-  
4 son. In separation of drugs -- and I am speaking of drugs  
5 now as distinct from a single drug that is formulated  
6 according to what we call "official formularies", in  
7 other words in one pharmacopoeia it appears and must be  
8 labelled by the manufacturer, must be identical in all  
9 respects, not only the active ingredients but the other  
10 ingredients as well. So it is an official formulation  
11 prepared by any manufacturer and bears the formulary  
12 identification, whatever it is, it must be identical in  
13 every respect.

14 THE CHAIRMAN: That included the size, the  
15 ingredients and everything?

16 DEAN MATTHEWS: Yes. In regard to the rest  
17 of the question, it depends on a number of factors, on  
18 what type of therapeutic action the drug would have. In  
19 the example Mr. Turnbull is quoting from, this drug does  
20 have a very specific effect on a very specific physiological  
21 function, and therefore a minute difference in the rate  
22 of absorption or the rate of dosage would have a dis-  
23 tinguishable effect, whereas other ingredients which have  
24 a more general effect would not be influenced nearly as  
25 much by the small difference in the size of the tablet or  
26 in the amount of filler used, and therefore the pharmacist  
27 would need to keep things of that nature in mind, as well  
28 as the actual physical differences which Mr. Turnbull has  
29 commented upon.

30 MR. TURNBULL: There are other problems



1 involved which are related to this overall question. These  
2 include the problem of duplication and the resultant  
3 multiplicity of drug preparations which have a high degree  
4 of similarity. The multiplicity of similar drug prepara-  
5 tions cannot be considered as wholly undesirable, provided  
6 that the ethics of the companies involved in their  
7 production are without question and that the medical and  
8 pharmaceutical professions are aware of the merits of the  
9 preparations and of the companies. Regrettably, stemming  
10 from duplications are the products of what we may choose  
11 to call nondescript, 'fly-by-night' companies of unknown  
12 ability and integrity which trade on the prestige enjoyed  
13 by others. The nondescript company capitalizes on the  
14 sale of only established, well-known drug preparations by  
15 often duplicating the exact nature, in form and appearance,  
16 of a prestige item which has resulted from high quality  
17 production methods and research. Quite naturally, they  
18 claim their products to be of similar quality, formulation  
19 and utility.

20 THE CHAIRMAN: Is that a very common  
21 occurrence?

22 MR. TURNBULL: In Canada, no.

23 THE CHAIRMAN: Do you mean it is fairly  
24 unusual?

25 MR. TURNBULL: Relatively so, yes sir.

26 THE CHAIRMAN: Does it constitute a serious  
27 problem?

28 MR. TURNBULL: Not yet, no.

29 THE CHAIRMAN: You have some qualms about  
30 the future?



1 MR. TURNBULL: Yes.

2 Counterfeiting presents a different problem  
3 in addition to the above problems in that packaging, colouring  
4 marking and all other outward physical appearances of the  
5 drug are made to be identical with the preparation  
6 marketed by a leading producer in the field. It is often  
7 sold as being the product of that leading producer. This  
8 is, of course, a criminal activity. I might add this  
9 activity to our knowledge is not being carried on to any  
10 great extent in Canada.

11 THE CHAIRMAN: And as far as Canada is  
12 concerned, "often" is little too strong as regards it  
13 being a product of that leading producer.

14 MR. TURNBULL: Of course the word "often"  
15 refers directly to the counterfeiting operation itself.  
16 If a dollar bill is to be counterfeited, it is often  
17 represented as being that of the Canadian currency.

18 THE CHAIRMAN: But "this is often sold" --  
19 that means the actual criminal act?

20 MR. TURNBULL: May I change that to read  
21 "It is often represented as being the product of that  
22 leading producer".

23 MR. WHITELEY: Have there been any criminal  
24 cases of this nature in Canada?

25 MR. TURNBULL: There has been none in Canada  
26 to my knowledge, sir.

27 THE CHAIRMAN: Then that suggestion as far  
28 as Canada is concerned, this statement is a bit too strong.  
29 It is not often represented as being a product as being  
30 produced in Canada?



1 MR. TURNBULL: That is correct, and I am  
2 not making a specific reference to Canada in this paragraph  
3 sir.

4 THE CHAIRMAN: But we are concerned with  
5 Canada.

6 MR. TURNBULL: The problem that such a  
7 situation does exist and exists not too far south of here,  
8 was in our minds.

9 THE CHAIRMAN: We are concerned of course  
10 with what is happening in Canada, and that is what we  
11 would like to know, what the application of the sentence  
12 is with regard to Canada. As I understand your evidence,  
13 this sort of thing has not happened as far as you know in  
14 Canada, not happened frequently?

15 MR. TURNBULL: That is correct.

16 The practising pharmacists in our many  
17 community pharmacies, as well as those in institutional  
18 practice, cannot possibly individually equip themselves to  
19 qualitatively examine all drug preparations in their  
20 possession, nor could they finance such an operation.  
21 Therefore, a pharmacy practitioner must rely upon his  
22 knowledge, gained over the course of years, and through  
23 his professional evaluation of information available to  
24 him, of the ability and the integrity of those from whom  
25 he purchases his pharmaceutical stock. At the same time, the  
26 pharmacist's inventory of pharmaceuticals is dictated, to  
27 a large extent, by the prescribing habits of the physicians  
28 in his community, and he will, thus, be guided by a  
29 contemplation of their requirements. Discretion in the  
30 writing of prescriptions is a prerogative of the physician



1 which should not be usurped by rules and compulsion.

2 THE CHAIRMAN: I think that brings up the  
3 point I was raising a little while ago.

4 MR. TURNBULL: I was going to read two  
5 more sentences.

6 THE CHAIRMAN: Right.

7 MR. TURNBULL: The profession of Pharmacy  
8 does not disagree with those who advocate that physicians  
9 might best prescribe drugs by their generic names. It is  
10 the pharmacist's duty and professional obligation to  
11 interpret the prescription desires of the doctor. In the  
12 absence of a physician's stated order by brand and/or manu-  
13 facturer's name, the pharmacist --- and only the pharmacist  
14 --- is in a position which enables him to assume the  
15 responsibility of selecting the proper preparation, be it  
16 brand-named or non-branded, in keeping with his knowledge  
17 of the required character of the drug, the reputation  
18 of manufacturers in that particular field, and coupled  
19 with known wishes of the physician and his own knowledge of  
20 the individual patient.

21 Here, sir, I would ask that the first  
22 sentence of that paragraph definitely not be divorced from  
23 remainder of the paragraph, in that it has led to rather  
24 erroneous statements in the past. I believe that this point  
25 brings us to the question you posed a few minutes ago.

26 I don't know that there is anything that I  
27 can add, either on a personal basis or as a representative  
28 of the Association concerning the proposals which apparently  
29 arose in the Province of Alberta. I am of the personal  
30 opinion that it is definitely a prerogative of the physician,





1 the individual physician, and only his duty to diagnose  
2 the needs of the individual patient and prescribe for that  
3 patient what he considers to be the very best drug  
4 therapy available for that patient, based on his own  
5 individual study and the knowledge that is available to  
6 him.

7                   At the same time we don't believe that in  
8 any way the practising pharmacist, private pharmacist,  
9 should be dictated to by those outside of the community,  
10 the health community and the individual community of  
11 any province or nation. We don't believe that outsiders  
12 should dictate to influence individual circumstances.

13                   THE CHAIRMAN: By "outsiders", do you mean  
14 the legislature?

15                   MR. TURNBULL: Legislators or people living  
16 in Toronto telling people in Owen Sound what they should  
17 do and prescribe, and what should be supplied on a pres-  
18 cription, or those who may choose to live in Edmonton  
19 telling someone in Ponoka what they should do as far as  
20 prescribing to meet the individual needs of the very  
21 private citizen.

22                   THE CHAIRMAN: Do you think this proposal  
23 that is made in Alberta takes away the doctor's rights to  
24 prescribe exactly what he wants for a patient?

25                   MR. TURNBULL: I am sorry, I would wish to  
26 read the proposal so that I definitely knew its wording.

27                   MR. FRAWLEY: I was going to say that  
28 because you see it was apparent that Mr. Turnbull did not  
29 understand from what he said about the people in Edmonton  
30 telling the people in Ponoka what they should do. The



1 whole proposal was entirely permissible, there was nothing  
2 mandatory about it at all. I rather think from Mr.  
3 Turnbull's answer he thought it was mandatory, and in view  
4 of what he said, I might read it.

5 MR. TURNBULL: I can read it at noon hour  
6 if you wish.

7 MR. FRAWLEY: "It is suggested that the  
8 Commission should look into: (1) The possibility of  
9 changes in federal and provincial legislation which would  
10 permit a pharmacist properly to dispense a generic  
11 equivalent even when a trade name is mentioned on the  
12 prescription, unless the doctor specifically states that  
13 only the trade name drug is to be provided".

14 That is what it says.

15 THE CHAIRMAN: As I understand that language,  
16 the doctor would still be in complete control. If he  
17 felt one drug made by one company was better for the purpose  
18 he had in mind, than any other similar generic drugs, he  
19 would specify that that drug was the one which must be  
20 used. If he was not so keen on that particular drug, he  
21 might not do so, and then the pharmacist would be in a  
22 position to make the choice.

23 I would like to get your advice on that,  
24 if your Association has any or if you have any personally,  
25 and bearing in mind this evidence which we had the other  
26 day with regard to hospital formularies that they have  
27 had no difficulty arising out of the fact that the doctors  
28 on the staff of the hospital do agree that certain drugs  
29 might be used, and that they were the ones that would be  
30 used when they were prescribed by a certain name. Would



1 it not seem that in a great many cases the doctors would  
2 not really insist on a particular drug, but might be  
3 satisfied with something which would be very much the same  
4 in therapeutic value, and that as the result of that, the  
5 druggist conceivably might have to stock lesser quantities  
6 and lesser varieties of drugs on their shelves? That is  
7 the sort of question that occurs to me arising out of the  
8 evidence we have had.

9 MR. FRAWLEY: Perhaps I might add at this  
10 point that it is quite clear from what Dr. Ross said in  
11 answer to your own question in page 866 in Volume 9, that  
12 his suggestion was carrying into the retail pharmacy in  
13 a broad way the formulary system. It was an endeavour to  
14 import and enlarge the formulary system, because he  
15 mentioned that after having read from his brief what I  
16 read a moment ago, Mr. Turnbull, Dr. Ross added extemper-  
17 aneously:

18 "I might say, sir, that this practice is  
19 being carried (on) with the approval of the  
20 medical staff of many of the hospitals in  
21 Alberta today to the benefit of the economy  
22 of the provision of drugs under our  
23 programmes."  
24  
25  
26  
27  
28  
29  
30



EMT/dpw

1 MR. TURNBULL: It is quite a tall order,  
2 Mr. Chairman. However, there are some comments I would  
3 like to make. First of all, permissive legislation is  
4 not necessary in this particular instance. If the physi-  
5 cian chooses to write a prescription by brand name, the  
6 pharmacist is obligated to provide this patient with that  
7 product by that specified brand name.

8 If the physician writes a prescription by  
9 generic name, and adds the manufacturer's name, the pharma-  
10 cist is similarly obligated to provide that. I believe  
11 this has all been brought out.

12 Now, there are several questions that arise  
13 in my mind in surveying a situation such as this: who is  
14 to choose the so-called generic equivalent - I believe  
15 that is the terminology used - to establish what product  
16 will be dispensed if the prescription is written by a  
17 brand and provided that the physician does not insist  
18 that that brand be dispensed? Will there be an overall  
19 descriptive formulary at the Provincial level and if so,  
20 who will choose products that will go into that formulary,  
21 and on what basis will such products be chosen?

22 Now, it is indicated as merely an enlargement  
23 upon the formulary system, but enlarging it to the retail  
24 level. Well that is fine. No permissive legislation is  
25 required. No enlargement of any formulary system is re-  
26 quired. In the communities, and we will go now to Ponoka,  
27 where I presume there are three or four physicians and  
28 maybe two pharmacists; I don't know ---

29 MR. FRAWLEY: A very large mental hospital.

30 MR. TURNBULL: I have friends that used to be



1 there, Mr. Frawley. I was going to say I had friends in  
2 Ponoka. If these four physicians, or any one of these  
3 physicians in Ponoka, was to tell the pharmacist in that  
4 area "Now, when I prescribe brand name so-and-so, I am  
5 doing so because I cannot remember the generic designation  
6 of this drug. This is your permission to dispense the  
7 product of your choice".

8 That basically is the principle of the  
9 formulary system, and the legislation is there to accom-  
10 plish this. No difficulty whatsoever. If the brand  
11 name is the only name that the physician cares to remember,  
12 but he does not necessarily want that, all he must do is  
13 go to the pharmacist in the area, and if the pharmacist  
14 takes unto himself his full professional responsibility,  
15 he will ensure that the physician's needs are met with  
16 what he considers to be the best possible substitute pro-  
17 duct or the product by the brand name. Provided of course  
18 those instructions have been laid forth by the physician  
19 in the first case.

20 THE CHAIRMAN: Would that not be a rather  
21 awkward situation in a place like Toronto where the drug-  
22 gist may get prescriptions from 50 or 100 doctors? He  
23 may have difficulty remembering which ones gave him such  
24 permission.

25 MR. TURNBULL: That is the problem, sir.

26 THE CHAIRMAN: Whereas permissive legisla-  
27 tion would mean unless a doctor specifically stated on  
28 the prescription that there was to be no substitute, the  
29 pharmacist would use his discretion.

30 MR. FRAWLEY: That is what he means. If





1 the doctor is prescribing Decadron, he has got to say  
2 Decadron and nothing else. If he doesn't say, then he  
3 can supply the other one, Gammacorten or Deronil or the  
4 generic ---

5 MR. TURNBULL: In the absence of the permis-  
6 sion of the physician, it is my opinion and the opinion of  
7 the pharmacists of Canada, that any substitution of any  
8 product other than the product named on the prescription  
9 would be extremely poor ethics, and tends towards poor  
10 therapeutics. It is not my personal opinion that the  
11 proposal that any overall formulary system at the retail  
12 level could possibly be operative because such a thing is  
13 only operative within the confines of a small health  
14 community such as a hospital or other institution.

15 THE CHAIRMAN: You are giving that as your  
16 own personal opinion?

17 MR. TURNBULL: Yes, sir.

18 THE CHAIRMAN: It is not the considered  
19 opinion of the Association as yet?

20 MR. TURNBULL: The Association has never  
21 given study to a proposal of this nature.

22 THE CHAIRMAN: Proceed then, Mr. Turnbull.

23 MR. TURNBULL: Continuing with the paragraph,  
24 the pharmacist is responsible for providing drugs which,  
25 to his knowledge, are completely unimpeachable. Pharma-  
26 ceutical excellence is his criterion. No two brands of  
27 the same drug are necessarily the same; nor are non-brands  
28 necessarily the same as brands.

29 It is repeated that the Canadian Pharmaceu-  
30 tical Association must take the stand that the degree of



1 quality control of drug products that is mandatory under  
2 present Regulations of the Food and Drugs Act is not such  
3 as to give sufficient insurance to the pharmacist that any  
4 given batch of the products of all manufacturers will meet  
5 the required specifications. Dispensing pharmacists have  
6 long since accepted the impracticality of subjecting modern  
7 drug products to analysis in the pharmacy and, as a conse-  
8 quence, find it necessary to fortify their own powers of  
9 observation and recognition by relying on the reputations  
10 of those manufacturers that experience has proven are  
11 deserving of their confidence. This Association recog-  
12 nizes this practice and will continue to urge the pharma-  
13 cists to observe the utmost caution before assuming the  
14 responsibility for any line of products where there is not  
15 acceptable assurance of full quality control. At the  
16 same time, the Association will continue to press for  
17 amended Regulations to help remove this area of uncer-  
18 tainty.

19 MR. FRAWLEY: Mr. Turnbull, will you clarify  
20 that phrase, "products where there is not acceptable  
21 assurance of full quality control"? Would you perhaps  
22 illustrate that? Are there some cases in which there is  
23 not acceptable assurance of full quality control?

24 MR. TURNBULL: I can't think of any specific  
25 example that I would like to make mention of here.  
26 Possibly I may, in a generalization, sir, indicate our  
27 first doubts about the products being imported from  
28 foreign countries of unknown control procedures, and this  
29 type of thing. That caused considerable consternation on  
30 the part of the pharmacy practitioner, in that suddenly



1 he was confronted with a situation that was new to him,  
2 and up to that particular time he had no assurances based  
3 on experience of the controls and what-not in those  
4 countries. Gradually this information becomes known.

5 Also when a new distributor suddenly  
6 appears before the pharmacists, and there is no basis  
7 of experience that this new distributor is either manufac-  
8 turing himself or obtaining products from sources which  
9 are, as I said, unimpeachable in the field.

10 THE CHAIRMAN: You mean this in the sense  
11 really that it is rather an agnostic position. You do  
12 not know that satisfactory quality control measures are  
13 being taken rather than that you do know they are not  
14 being taken?

15 MR. TURNBULL: That is correct.

16 THE CHAIRMAN: Sometimes, and this is under-  
17 standable, the pharmacist might decline to use a product  
18 of a certain company simply because he has not had any  
19 information satisfactory to him?

20 MR. TURNBULL: That is correct.

21 THE CHAIRMAN: That their products are pre-  
22 pared under conditions that are proper and suitable, but  
23 he is passing no judgment on their actual suitability or  
24 reliability. He is merely saying "I don't know, therefore  
25 I don't use them"?

26 MR. TURNBULL: Yes.

27 MR. FRAWLEY: I suppose the leading manufac-  
28 turers, Pfizer, Cyanamid, Abbott and all the rest import  
29 from foreign countries basic raw materials. Basic drugs.

30 MR. TURNBULL: I suppose so.



1 MR. FRAWLEY: From Japan, Europe and every  
2 place, just where these so-called distributors import  
3 from. They are all trading in part or in whole from the  
4 same basic sources.

5 MR. TURNBULL: I did not make any reference  
6 to that.

2 7 THE CHAIRMAN: I am making no objection to  
8 your question, Mr. Frawley, but I think there will be a  
9 time later on for all this.

10 MR. TURNBULL: From the physician's view-  
11 point, brand names and brand-named products undoubtedly  
12 have certain advantages, including (1) relatively easy to  
13 remember, (2) relative quality is known, (3) usually  
14 associate name with a company, (4) recall to mind distinc-  
15 tive physical properties, and (5) use assures that exactly  
16 the same product is supplied to his patients or to the  
17 same patient at different times. To the pharmacist, the  
18 same factors are advantageous, although prescribing by  
19 chemical or common name designations which permit dispen-  
20 sing of known, reliable brands or non-brands would enable  
21 him to better utilize his own professional training and, at  
22 the same time, permit him to carry a less extensive inven-  
23 tory.

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E/MR/hm 1 MR. TURNBULL: As mentioned previously, a pharmacist's  
2 inventory is speculative in that he must anticipate the  
3 specific request contained in prescriptions written by  
4 physicians. "A Prescription Drug Survey" (Walker and Hughes:  
5 C.Ph.J., Vol. 94, No. 5 (May, 1961) p. 22) published in the  
6 Canadian Pharmaceutical Journal analyzed 902 prescriptions  
7 supplied by Prescription Services Incorporated of Windsor,  
8 Ontario, (665 consecutive prescriptions written during  
9 February, March and April of 1960 and 237 consecutive  
10 prescriptions in June, 1960). The results are:

11 -- of the 902 prescriptions, 13 for one  
12 reason or another could not be analyzed

13 -- of the 889 balance: 45 (5%) were

14 extemporaneously compounded

15 63 (7) were filled using non-proprietary  
16 name products

17 781 were written for brand name products.

18 THE CHAIRMAN: That is, the doctors had  
19 written them in that way?

20 MR. TURNBULL: That is correct.

21 -- the 781 constitute 87.95% of total and  
22 represented 54 manufacturers

23 -- of the 781: 376 (42.3% of full total)  
24 products contained more than one medicinal  
25 ingredient;

26 - 405 (45.56% of full total) contained  
27 single medicinal ingredient;

28 -- of the 405: 121 (13.61% of total) were  
29 brands for which no other preparation  
30 was available.





1 - 35 (3.93% of total) products can be pro-  
2 cured under more than one brand name  
3 - 249 (28.0% of total) can be procured under  
4 a non-proprietary name and/or brand  
5 name.

6 THE CHAIRMAN: One question arises, or  
7 occurs to me in connection with the statement 376 or  
8 42.3% of the total products contained more than one  
9 medicinal ingredient. Does that lead to the conclusion  
10 that there is only one manufacturer?

11 MR. TURNBULL: No.

12 THE CHAIRMAN: Can only be purchased from  
13 one source?

14 MR. TURNBULL: No. This was simply a  
15 statement concerning the composition of the products.

16 THE CHAIRMAN: Oh yes, but you break down  
17 the others. You break down the 405 into whether one brand  
18 or two brands or no brand, but you do not break down the  
19 376. I wondered if that meant there was only one source  
20 of supply?

21 MR. TURNBULL: The editors of the survey  
22 indicated that they had concentrated on the 405 which are  
23 the single medicinal ingredient preparations, as being  
24 those that are most often available to a generic name  
25 designation; and that it would be extremely difficult for  
26 a physician to write -- once you get into the complicated  
27 multi-ingredient formulation -- to write a prescription of  
28 that nature so they swung over to simply the single  
29 medicinal ingredient prescription survey because, they,  
30 in most instance, lend themselves to generic name designations.



1 THE CHAIRMAN: Two or more ingredients are  
2 not, certainly, so readily available from more than one  
3 source?

4 MR. TURNBULL: No, and normally when they  
5 are available they would be available under some type of  
6 brand or trade name designation as well.

7 THE CHAIRMAN: You have a number here, 35  
8 of the 405 can be procured under more than one brand name.  
9 Would that apply to some of the 376 as well?

10 MR. TURNBULL: There is that possibility.  
11 Very few.

12 MR. CARIGNAN: Do most of the compounds have  
13 an official name?

14 MR. TURNBULL: Most of the compounds would  
15 have an official name --?

16 MR. CARIGNAN: Out of the 376 products  
17 containing more than one ingredient, how many approximately  
18 would be expected to have an official name?

19 MR. TURNBULL: Very, very few would have  
20 an official name which designated the recipe of the  
21 preparation. Twenty-five years ago we would have said  
22 quite a number would be made according to some official  
23 recipe, recognized official recipe. Not today.

24 THE CHAIRMAN: I wonder what is the reason  
25 for that?

26 MR. TURNBULL: The recipe books cannot  
27 keep up with them. That's pretty well it. That's pretty  
28 well the answer sir.

29 In summary, of 344 prescriptions, only 63  
30 (for 20 different drugs) were written by physicians by a



1 generic name. The remaining 781 could be filled only by  
2 the named product on the prescriptions because they were  
3 written that way, and the survey indicated that, of these,  
4 405 might lend themselves most readily to the supplying of  
5 a non-proprietary product, although 121 were not available  
6 from more than one firm.

7 The "Compendium of Pharmaceutical Specialties,  
8 1960" published by the Association under the editorship  
9 of Dean F. N. Hughes, describes, in monograph form, 7776  
10 products. An analysis of these 7776 products (not including  
11 additional monographs in subsequent Supplements to this  
12 reference text) is appended as Appendix G. In summary  
13 form, the results of this analysis were:

	<u>Number</u>	<u>Per cent</u>
14 Total number of products	7776	100.0
15 Hospital-only products	85	1.09
16 And these, if I may just refer back to Professor Summers'		
17 presentation yesterday in which he noted the hospital-only		
18 products as opposed to those that are also available in		
19 retail, 85.		
20 Mixtures (more than 2 active ingre-		
21 dients)	4593	59.07
22 Generic named, single ingredient,		
23 regular dosage forms	2010	25.85
24 Generic named, single ingredient,		
25 regular dosage, one company	591	7.60
26 Generic named, single ingredient,		
27 special dosage form	277	3.56

28 THE CHAIRMAN: Special dosage form means  
29 that it is a special dosage for that particular patient?  
30



1 Is that what you mean?

2 MR. TURNBULL: No. It would be a special  
3 dosage form peculiar to say one company only and not known  
4 to other companies, or not regularly available.

5 Generic named, single ingredient,

6 special dosage, one company 55 0.71

7 Brand-named only, single ingredient,

8 regular dosage 156 2.01

9 Brand-named only, single ingredient,

10 special dosage 9 0.16

11 \*Often companies sell products which fall within  
12 the survey classification "single, regular, generic".

13 The above 2010 products represent 434 different  
14 active ingredients.

15 This survey would indicate that of 7776  
16 available in Canada, only 2010 (25.85%) represent single  
17 ingredient products available in customary dosage forms  
18 which are available from more than one company and which  
19 could be prescribed by generic name designations. A  
20 further 923 (11.87%) involving special circumstances are  
21 available which could be prescribed by certain non-  
22 proprietary nomenclature.

23 THE CHAIRMAN: All of these 7776 are  
24 prescriptions items are they?

25 MR. TURNBULL: Yes sir, described in the  
26 Compendium.

27 THE CHAIRMAN: I did not notice in the  
28 paragraph it said specifically.

29 MR. TURNBULL: They are products which are  
30 available for prescription usage. They are not necessarily



1 legislatively restricted to prescription only sale.

2 THE CHAIRMAN: I was thinking of drugs like  
3 Aspirin, Bufferin, Anacin.

4 MR. TURNBULL: I do not believe that you  
5 will find these in here. However, in some circumstances  
6 they are prescription drugs.

7 THE CHAIRMAN: They could be, yes, but they  
8 are also over the counter drugs judging by the advertising.

9 MR. TURNBULL: Yes.

10 It would be erroneous to conclude that  
11 approximately one-third of all prescriptions could be  
12 written generically, as no figures related to potential  
13 utilization of the drugs so classified are known. Further,  
14 there is no way of determining the extent to which the  
15 availability of other specialty formulations and/or mixtures  
16 is made possible through the sale of the single ingredient  
17 product by any one manufacturer. It can be concluded,  
18 however, that an extremely cautious searching-out of all  
19 facts should be undertaken by any persons of authority who  
20 might be tempted to listen to those who would advocate  
21 rules and regulations to regiment prescription writing  
22 habits of physicians in both private and institutional  
23 practice.

24 FOREIGN SOURCES OF DRUGS

25 In any discussion relative to the economics  
26 of medical care, including factors related to the pricing  
27 of drugs, we believe that the Canadian scene and way of  
28 life must be acknowledged. It is well known that our  
29 standard of living in Canada is higher than that of many  
30 other nations; that our wage levels greatly exceed those of





1 some foreign countries; that we wish to continue a greater  
2 development of industry and, at the same time, even raise  
3 our present high academic standards which will do much  
4 to encourage industry and research development to the  
5 mutual advantage of the general public, the professional  
6 practitioner and the industrialist. We have attempted to  
7 remain outside of the more heated discussions relative to  
8 brands and non-brands in that the pharmacy practitioner  
9 has no quarrel with industry in other countries that are  
10 able to produce goods, whether they be drugs or not, at  
11 prices which, to us, appear ridiculously low, except that  
12 the importation of such may have an adverse effect on the  
13 Canadian employment scene and on Canadian development,  
14 generally.

15 Imports and Exports:

16 Canada's pharmaceutical industry contributes  
17 a reasonable amount to our export trade, although imports  
18 will exceed exports. In 1959, it is reported that imports  
19 represented 11.1% of the total Canadian market for  
20 medicinals and pharmaceuticals, \$165,238,579.00. During  
21 the same period exports totalled \$6,741,878.00. Thus,  
22 net imports (imports less exports) represented 7.0% of  
23 the total Canadian market.

24 (Source: D.B.S. The Medicinal and  
25 Pharmaceutical Preparations  
26 Industry 1959)

27 Taxes and Tariffs:

28 Fiscal policy related to tariff structures  
29 is spelled out in the Director's Statement. On these we  
30 can make little comment except to point up the undoubted



1 difficulties which must frequently confront inspectors  
2 who must classify incoming goods as bulk medicinals or as  
3 chemical products. Tariffs often differ greatly.

4 By amendments of a few years ago, excise  
5 taxes on bulk quantities of finished pharmaceuticals are  
6 applied against the package sizes in which the importer  
7 intends to sell the product in Canada. The Association  
8 certainly commends this action as being more fair to those  
9 companies which both manufacture and package in Canada,  
10 and as being a move which will enhance the creation of more  
11 extensive manufacturing procedures here.

12 Except for five specific drugs (not drug  
13 classes), an 11% federal sales tax is applied against sales  
14 of all drug preparations. This tax greatly increases the  
15 financial burden to be borne by the patient, often at a  
16 time when his earning power is reduced. It, of course,  
17 contributes adversely to the cost of drugs in Canada when  
18 compared with costs in other countries. Sales tax is not  
19 paid by governments, institutions and hospitals unless the  
20 latter use them in selling activities which are profit  
21 making. The Association has each year, for many years,  
22 urged the Federal Government to repeal the Sales Tax Act  
23 as it applies to drugs and pharmaceutical preparations  
24 and therapeutic items used in the diagnosis and treatment  
25 of disease.

26 Provisions of the Income Tax Act which  
27 acknowledge payments for prescribed drugs as deductible  
28 items when calculating personal income tax came about in  
29 1958 after long-standing representations by our Association.  
30 These provisions, of course, add to the 'paper work' burden



1 of the community pharmacist in the rendering of overall  
2 pharmaceutical services.

3 THE CHAIRMAN: Mr. Turnbull, I think this  
4 next item you are coming up to is a fairly lengthy one,  
5 hospital and institutional purchasing. We had better have  
6 a break.

7

8 ---Short recess.

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1 HOSPITAL AND INSTITUTIONAL PURCHASING

2 It is only during the past few years that  
3 there has been any degree of public attention drawn to  
4 drug costs in hospitals and similar institutions. The  
5 method of purchasing drugs by hospitals has, however,  
6 experienced no substantial changes for many years. Prior  
7 to government-sponsored hospitalization schemes coming  
8 into existence, the hospital pharmacy was considered as a  
9 profit-making department. Today, its costs, in spite of  
10 the excellence of modern drug therapy, are suddenly viewed  
11 as contributing significantly to the overall expenses of  
12 patient care.

13 The Director's Statement makes many references  
14 and comparisons to drug prices at all purchasing levels.  
15 In paragraph 138, it is stated that "There are several  
16 factors which make the prices of drugs purchased through  
17 a drugstore higher than the prices paid for the same drug  
18 by a hospital". Although this statement does not relate  
19 to similar purchase levels or conditions under which drugs  
20 are made available, we feel that the situation described  
21 is to be conceded as unfair and unrealistic.

22 That paragraph points out, however, some of  
23 the differences: (1) Hospital costs do not include the 11%  
24 sales tax applied to drugs, (2) Hospitals buy in large  
25 quantities with resultant larger discounts or special quan-  
26 tity prices, (3) Hospitals purchase larger package sizes;  
27 bulk quantities, of course, require a re-packaging program,  
28 but savings may result from the use of lay personnel super-  
29 vised by a pharmacist, thus eliminating the higher expenses  
30 necessary for dispensing by licensed pharmacists in.



1 community outlets, (4) Standard dosage forms are more  
2 commonly used by hospitals, while a greater variety of  
3 dosage forms are available from the community pharmacy,  
4 (5) The retailer must take a mark-up on a price which is  
5 already higher than that paid by hospitals.

6 In addition to the above points of difference,  
7 there are several which the Director's Statement  
8 has failed to record:

9 (1) The lower number of demands made upon a  
10 hospital pharmacy for a variety of drugs  
11 and preparations thereof, such as is experienced by the community pharmacist who  
12 serves a great variety of individual physicians in his area.

13 THE CHAIRMAN: Do you mean by that the  
14 smaller variety of prescriptions that would be ordered in  
15 the hospital or the smaller total number?

16 MR. TURNBULL: Smaller variety.

17 THE CHAIRMAN: I think we had some statements  
18 that in the hospital they had in total a much greater  
19 number of prescriptions than in one pharmacy.

20 MR. TURNBULL: In only one pharmacy.

21 THE CHAIRMAN: Unless it was a very large  
22 pharmacy.

23 MR. TURNBULL: The variety of drugs and  
24 preparations thereof.

25 (2) A hospital usually has larger sums of  
26 money available to invest in larger quantities and has a budget which permits extensive pre-use purchasing.





(3) Hospital purchases are often made by tender.

(4) A formulary system enables the hospital pharmacy to reduce its number of brands (or non-brands) and dosage forms.

(5) Greater storage facilities in hospitals.

(6) 'Free goods' often available to hospitals with the purchase of large orders or special contracts. The amount of free drugs available for clinical investigation is said to be not great, but it must have an ultimate effect on overall drug utilization.

A comparison of prices of individual items must take into account the several points mentioned above. No fair comparison can be made between hospital prices and retail prices on the basis of total inventory in that a hospital stocks certain preparations and dosage forms, such as injectibles, which may not be carried by the average retail pharmacy. On an individual basis, many of these are quite expensive. Also, inventories in the hospital are maintained to satisfy the demands of the hospital's medical staff and the pharmacist, in his role as a purchasing agent, is required to keep inventories within budget limits without sacrificing quality. Inventories are not subjected to widespread, individual likes and dislikes of practitioners and the hospital is not involved in any profit motive considerations.

Any comparison between the purchasing agent role assumed by the retail pharmacist and by the hospital pharmacist is complicated by the fact that (a) the hospital



1 pharmacist provides the medical staff with drugs which  
2 they have selected to ensure rational therapy within  
3 agreed specifications and at an economical price dictated  
4 by the economy of the institution; (b) the hospital phar-  
5 macist is accountable to the administrator of the institu-  
6 tion and to a board of governors and, thus, adopts effec-  
7 tive procedures to satisfy his superiors, as opposed to  
8 the procedures of the retail pharmacist dictated by our  
9 free enterprise system; (c) a hospital pharmacist normally  
10 buys for a known demand without the element of speculation  
11 encountered in anything but an assured market; (d) hospi-  
12 tal purchasing may take advantage of special prices  
13 offered on long-term contracts based on volume over a  
14 specified period; (e) purchasing in accordance with a  
15 stipulated budget prepared in keeping with the dictates  
16 of years of experience, as well as experts in the full  
17 hospital field, assists the hospital pharmacist who has  
18 no temptation towards reorganizing the budget to satisfy  
19 the desires of other departments such as may be experienced  
20 by the retail pharmacist who is often his own landlord and  
21 tenant.

22 MR. WHITELEY: What is the last point you  
23 are speaking of?

24 MR. TURNBULL: My reference there would be  
25 to the desire of the retail pharmacist to ensure that his  
26 establishment is completely up-to-date and attractive to  
27 the, shall we say, customers in the community that he is  
28 serving, while the number of dollars available to him to  
29 possibly take advantage of, shall we say, quantity purcha-  
30 sing, to speculate on the use of a quantity purchase,



1 might not be possible in view of his need to use the same  
2 dollars in modernization of his physical facilities or  
3 some other project directly related to the commercial  
4 side of the business he is operating in conjunction with  
5 his pharmacy.

6 MR. WHITELEY: That would be a capital cost?

7 MR. TURNBULL: But it does involve dollars  
8 and quite a few of the smaller retailers don't have the  
9 dollars whether for capital cost or for the immediate  
10 needs of his inventory and stock.

11 MR. WHITELEY: He may put his money into camera  
12 supplies rather than drugs.

13 MR. TURNBULL: That could well be.

14 THE CHAIRMAN: Is there a great difference  
15 there between the retail pharmacist and hospitals? The  
16 retail pharmacist may be short of dollars, but sometimes  
17 hospitals are short of dollars also.

18 MR. TURNBULL: The greatest difference is  
19 when the retail pharmacist is short of them they are his  
20 own dollars.

21 THE CHAIRMAN: If you haven't got them it  
22 doesn't matter if they are yours or somebody else's.

23 MR. TURNBULL: That is true.

24 Hospital Plans' Drugs:

25 Paragraph 161 of the Director's Statement  
26 makes reference to the difficulties sometimes encountered  
27 by certain individuals in the financing of their drug  
28 needs following discharge from a hospital or a rehabilita-  
29 tion institution. The complaint here seems to be that  
30 there are people who have experienced periods, of varying



1 lengths, during which they have had their every need  
2 taken care of and then, upon discharge, suddenly cannot  
3 finance their own needs, including drugs, and must, there-  
4 fore, be readmitted to the hospital or institution. In  
5 other words, because the discharged patient, or someone  
6 on his behalf, did not assume bills which might amount to  
7 \$50 a month for drugs received from private pharmacy prac-  
8 titioners, it was found necessary to readmit him to an  
9 institution where his maintenance costs \$210 a month.

10               It is obvious that the agency involved in  
11 such instances is concerned with the fact that such \$50  
12 worth of drugs would not cost the institution \$50. It,  
13 therefore, asks why it should be necessary for the agency  
14 to agree to pay that higher amount so that the patient  
15 being rehabilitated could lead a normal life. This  
16 situation reflects the sometimes referred to 'subsidy' of  
17 hospital drug costs which is being borne by ambulatory  
18 patients. It could be said, also, that it reflects upon  
19 a philosophy which sees fit to bear the full cost of opera-  
20 ting an institution for a patient who does not require  
21 institutional care, rather than guide that patient's  
22 rehabilitation by assisting him with the provision of the  
23 cost of drugs obtained from the pharmacist of his own  
24 choice.

25               Hospital bed utilization continues to be a  
26 problem facing those who administer various hospital  
27 schemes. It is recognized by them that drug therapy has  
28 done much to reduce the period of hospitalization per  
29 patient, thus enabling hospitals to care for a greater  
30 number of patients each year. It is interesting to note,





1 at this point, that a memorandum on "Hospital Drug Costs"  
2 issued by the British Ministry of Health to hospitals on  
3 August 15, 1961, pointed out that there is a danger of  
4 pushing economy measures in hospitals too far with the  
5 result that patients may not get the best treatment avail-  
6 able. This memorandum further said, "This could mean  
7 that their stay in hospital might be prolonged which,  
8 apart from the human consideration, could have the effect  
9 of only increasing hospital costs", and further that,  
10 "One extra day in hospital would cost more than the equi-  
11 valent of four weeks' supply of drugs and dressings". It  
12 would, therefore, seem rational in the interests of the  
13 needy, discharged patient and the economy, in general,  
14 that drugs required for a certain definite out-patient  
15 period be provided in keeping with the patient's personal,  
16 private desires through the pharmacist of his choice.

17 Consumer Subsidy of Institutional Prices:

18 The retail pharmacist purchases drugs at  
19 prices set by the manufacturer without being able to take  
20 advantage of contractual agreements and other competitive  
21 practices which are characteristic of purchases made by  
22 institutions. In paragraph 412, it is stated that, "It  
23 seems clear that these practices tend to increase rather  
24 than decrease the selling prices of drugs". There are  
25 many factors entering into mass purchasing which influence  
26 the ultimate prices at which drugs and other items can be  
27 made available. It has been said that many savings occur  
28 in mass manufacturing and distribution steps and that such  
29 savings can be passed along only to other than the private  
30 individual purchaser. However, it must be assumed that





1 consumer prices subsidize the price at which the same  
2 drugs are offered to hospitals, institutions and government  
3 departments. Such a subsidy may be direct or indirect in  
4 that the consumer demand may have been created by the  
5 larger company which enjoys the confidence of the indivi-  
6 dual practitioners, although the same company may not be  
7 the ultimate supplier to the lower price purchasing group.

8           The offering of low prices to hospitals and  
9 governments was established when a much lower proportion,  
10 possibly around 10%, of the total distribution took place  
11 through these channels. At that level, that is the 10%  
12 level, most of the special discount was probably written  
13 off as advertising. In late years, the proportion has  
14 risen rapidly to approximately 37% and, thus, any write-  
15 offs to advertising will be substantial if the practice  
16 is continued. Possibly these situations have prevented  
17 some price reductions which might have been expected to  
18 occur at the retail level in the normal course of events.

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/JW/hm

1 THE CHAIRMAN: Mr. Turnbull, I gather from  
2 that paragraph, that your view is that low prices to  
3 hospitals are somewhat subsidized by the prices which  
4 have to be paid by the private purchaser to the pharmacist?

5 MR. TURNBULL: Yes sir.

6 THE CHAIRMAN: Have you any suggestions for  
7 dealing with it?

8 MR. TURNBULL: I believe that later on in  
9 this same section we deal with it. I would also refer  
10 back to our earlier comments concerning equal price  
11 for equal quantity -- the principle of equal price for  
12 equal quantity and equal quality at all purchasing levels.

13 THE CHAIRMAN: You would allow a difference  
14 at the purchasing level, the difference in the wholesale  
15 level as compared to the sale to the retailer, would you?  
16 That is a different level?

17 MR. TURNBULL: That is part of the distri-  
18 bution chain and not necessarily at purchasing level, the  
19 wholesale level ---

20 THE CHAIRMAN: I am not sure what you mean  
21 by "purchasing level".

22 MR. TURNBULL: Basically the reference there  
23 to the purchasing level would be the level at which  
24 consumers in some classification or other, be they private  
25 or institutionalized, would be receiving drugs.

26 THE CHAIRMAN: The consumer in many cases  
27 is a hospital?

28 MR. TURNBULL: That is correct, he is  
29 institutionalized.

30 THE CHAIRMAN: That is, the consumer itself



1 is the hospital because it provides it without any extra  
2 charge. It doesn't sell it specifically to the patient  
3 who is in the hospital, it supplies the patient under  
4 present plans, drugs free, as far as the patient is  
5 concerned as an individual.

6 MR. TURNBULL: That is correct.

7 THE CHAIRMAN: So the consumer is a  
8 hospital and it buys and does not resell, but the whole-  
9 saler buys for resale, and is this considered a different  
10 level of purchasing?

11 MR. TURNBULL: I think in the trading chain  
12 of events, the wholesaler is one of the links in the  
13 trading chain, rather than at the final distribution level.

14 THE CHAIRMAN: Your proposal is whether  
15 selling to a hospital or to a retail pharmacist or to  
16 anyone else, except maybe a wholesaler.

17 MR. TURNBULL: Yes.

18 THE CHAIRMAN: The price should be the same  
19 for goods of the same quality and quantity, is that it?

20 MR. TURNBULL: Yes sir.

21 THE CHAIRMAN: And differences would occur  
22 only, presuming they are for the same quality, where the  
23 quantities differ?

24 MR. TURNBULL: Yes.

25 THE CHAIRMAN: Would you think the variation  
26 would depend upon cost savings only?

27 MR. TURNBULL: That is correct.

28 THE CHAIRMAN: Cost savings which arise  
29 in connection with larger orders?

30 MR. TURNBULL: Yes. In other words if one



1 price is correct, the other price must be wrong.

2 THE CHAIRMAN: That might increase the  
3 expenses of hospitals?

4 MR. TURNBULL: We comment on that in this  
5 section.

6 THE CHAIRMAN: And reduce the cost to the  
7 private individual.

8 The Formulary System:

9 There have been many claims and counterclaims  
10 made relative to the "formulary system of dispensing" in  
11 hospitals. It would appear that such a system is related  
12 in the lay mind to a system whereby drugs are provided  
13 only by generic name. This may be correct in certain  
14 specific instances, but it is not necessarily the intent  
15 of the system brought into effect by the Pharmacy and  
16 Therapeutics Committee of a hospital. The formulary system  
17 merely provides a form of authorization to the hospital  
18 pharmacist to dispense, regardless of the brand name  
19 prescribed, a product by brand name or other designation  
20 as set by the committee and agreed to by the medical staff.

21 The community pharmacist does not have the  
22 same prerogative and, ethically, cannot substitute one  
23 manufacturer's product for that of another without reference  
24 to the individual prescribing physician. The formulary  
25 system as practised in our hospitals, is not, however, a  
26 system of substitution, as the medical staff is aware of, and  
27 has previously agreed to the rulings which will guide the  
28 dispensing of his drug orders.

29 This system works to effect reduced costs  
30 to the hospital. From the manufacturer's point of view,



1 the formulary system tends to substantially reduce, in  
2 hospitals and government institutions, or, indeed,  
3 eliminate the normal protection afforded his brand name.  
4 With sales made to hospitals under the tender system and the  
5 elimination of brand name protection, the manufacturer is  
6 forced into an extreme competitive field, price-wise, if  
7 he wishes to benefit by a coincident prestige and pro-  
8 motional value of having his particular brand available  
9 to physicians in the hospital. Very often, as a result of  
10 the above, tendered prices of a manufacturer will be  
11 determined on the basis of a variable cost plus a slight  
12 excess which may be applied to reducing overhead. He  
13 makes a contributory profit in that he receives an amount  
14 in excess of his variable cost, but he may not realize  
15 a clear profit on such sales.

16 THE CHAIRMAN: Mr. Turnbull, is this simply  
17 a statement of opinion as to what happens or have you  
18 factual data indicating that that is actually what happens?

19 MR. TURNBULL: This is a statement of  
20 opinion, sir.

21 THE CHAIRMAN: We are dealing with the  
22 situation which in your view is the manufacturer is forced  
23 into an extreme competitive field pricewise and has to  
24 make very big cuts in what otherwise would be his price  
25 in order to obtain any orders from the hospital?

26 MR. TURNBULL: Yes.

27 THE CHAIRMAN: With regard to your proposal  
28 that uniform prices at similar levels should prevail,  
29 would you eliminate tenders?

30 MR. FRAWLEY: I didn't catch that.





1 THE CHAIRMAN: Would you eliminate tenders?

2 MR. TURNBULL: It would be assumed that  
3 tenders would not be necessary, sir.

4 THE CHAIRMAN: There is not much purpose  
5 in calling for tenders if you are going to get the same  
6 price from everyone and you know it in advance.

7 MR. TURNBULL: It would be assumed -- I  
8 would like to correct that, that everybody is going to  
9 indicate the same price in advance. We are not referring  
10 to fixing of prices in any way, fixing of prices in any  
11 individual company, of course.

12 THE CHAIRMAN: If you have the company's  
13 suggested price list and you know that on tender that is  
14 what you are going to get, and you are not going to get  
15 anything else --

16 MR. TURNBULL: Right.

17 THE CHAIRMAN: -- there would not be much  
18 point in calling for tenders?

19 MR. TURNBULL: That is correct.

20 MR. WHITELEY: You would require a company  
21 to determine in advance what its price would be for any  
22 possible quantity?

23 MR. TURNBULL: There are certain exceptions  
24 of course there, to quantities over and above what could  
25 be considered as normal large quantities.

26 I believe in the Green Book presentation  
27 it even records prices for a certain product in four  
28 million quantity orders. Well, possibly there we might  
29 be getting into the tender field, because a four million  
30 quantity order is hardly a useable supply.



1 MR. WHITELEY: That is the point I was  
2 making. Unless you determine in advance the price for  
3 any possible quantity, then there would have to be a  
4 tendered price, because they would not have any prices  
5 available.

6 MR. TURNBULL: That is correct, where there  
7 was no price available.

8 THE CHAIRMAN: Your proposal would include  
9 the setting of prices for certain quantities, would it  
10 not?

11 MR. TURNBULL: For the publishing by a  
12 manufacturer of the prices he was to receive for his  
13 products for certain quantities.

14 THE CHAIRMAN: For certain quantities?

15 MR. TURNBULL: Yes.

16 THE CHAIRMAN: But it might not go beyond  
17 a certain maximum?

18 MR. TURNBULL: That is correct.

19 THE CHAIRMAN: As far as he would be  
20 concerned, if your proposal went into effect, it would  
21 only be in amounts that exceeded that maximum that there  
22 would be any question of tender?

23 MR. TURNBULL: Yes.

24 MR. WHITELEY: Would he also be required  
25 to work out prices for any sort of packaging?

26 MR. TURNBULL: They should bear a relation-  
27 ship, yes.

28 MR. WHITELEY: I mean, he would have to  
29 work these out in advance. Say there was a large order  
30 for a hospital which had a type of packaging which was not



1 used in the normal trade.

2 MR. TURNBULL: I can think of no instances  
3 other than possibly what Professor Summers mentioned  
4 yesterday, where one particular product which he quoted  
5 is made available in a hospital package only. It  
6 not available to any other distribution level.

7 That, of course, does not enter into this,  
8 but I do think in that instance that the small hospital  
9 that is able to buy in quantities comparable to, shall we  
10 say, the Federal Government, should have the opportunity  
11 of purchasing that particular hospital package in the same  
12 quantity and at the same price as the Federal Government.

13 MR. WHITELEY: I was thinking of the  
14 information given us by the Sandoz Company that certain  
15 products are put up in units of a size which they think  
16 is the normal treatment, but in a hospital they might  
17 decide to take this product in larger units and do their  
18 own dispensing.

19 MR. TURNBULL: Yes, it has to be assumed  
20 that there are retail pharmacists who could also purchase  
21 in quantities comparable to that hospital as well.

22 MR. WHITELEY: They might have no particular  
23 use for this size package.

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1 MR. TURNBULL: Falling back into my own  
2 experience, which is now going back some 10 or 12 years,  
3 I can remember, sir, when we used to buy in quantities  
4 of 50,000, but we bought at retail prices available to  
5 the retail pharmacy. Now I have no information to say  
6 What that same 50,000 might be available for at the  
7 hospital or government level.

8 THE CHAIRMAN: What Mr. Whiteley had in  
9 mind was buying for retail sale, unless you were going to  
10 do some repackaging. In hospitals, instead of having  
11 boxes of 12 tablets or bottles of 24 tablets, they might  
12 buy in bottles containing a 1,000 tablets, something of  
13 that kind, and the packaging would be much less expensive  
14 for the 1,000 in one package than if you had a thousand  
15 units in 50 packages.

16 MR. TURNBULL: A thousand units, gentlemen,  
17 is not an unusual size for many retail pharmacies to pur-  
18 chase.

19 THE CHAIRMAN: To repackage then for their  
20 customers?

21 MR. TURNBULL: Oh, yes.

22 THE CHAIRMAN: There are many drugs which  
23 are not purchased that way?

24 MR. TURNBULL: There is a limited number,  
25 yes.

26 MR. FRAWLEY: When you spoke of your personal  
27 experience 10 years ago, you would buy in 50,000 lots at  
28 retail prices, would you not get a quantity discount?

29 MR. TURNBULL: Presumably we were getting  
30 quantity discounts at the retail buying level. Retail



1 purchasing level.

2 THE CHAIRMAN: Definitely getting  
3 away from the quantity discount.

4 MR. TURNBULL: Yes.

5 THE CHAIRMAN: If you bought in 50,000 lots,  
6 you might pay more than if a mental institution bought in  
7 50,000 lots?

8 MR. TURNBULL: I said I did not know whether  
9 there was a price differential, but I assumed there was  
10 quite a price differential.

11 However, drug manufacturers are not philan-  
12 thropic organizations. In order to receive a normal  
13 profit return on his total sales of a specific product,  
14 the manufacturer must then rely on his sales to retail  
15 pharmacies to return him a price which not only covers  
16 variable costs, but also bears a disproportionate share of  
17 his fixed overhead. Thus, the retail pharmacist, and  
18 through him the ambulatory patient in need of medication,  
19 assumes a disproportionate share of this manufacturer's  
20 fixed cost.

21 THE CHAIRMAN: That is the same point you  
22 were making before?

23 MR. TURNBULL: Yes.

24 MR. WHITELEY: Have you considered what the  
25 effect of this might be on importations?

26 MR. TURNBULL: I think the overall effect  
27 would be relatively the same, would it not, Mr. Whiteley?

28 MR. WHITELEY: Well, I judge what you have  
29 in mind is that the price to institutions is going to  
30 increase, and if that is the effect, it may become more





1 attractive to buy on import.

2 THE CHAIRMAN: The British Ministry of  
3 Health are now doing what in regard to some?

4 MR. TURNBULL: I am not too sure of your  
5 question. You are inferring that we would then rely upon  
6 other lands for the provision of our drugs because we  
7 would presumably have somebody in our nation who would  
8 see fit to import from these other lands and make these  
9 preparations available to all buying levels at one price  
10 in consideration of quantity, of course.

11 MR. WHITELEY: No, no.

12 MR. TURNBULL: And therefore we would elimi-  
13 nate our Canadian manufacturing facilities because the  
14 drugs coming in from other lands must be cheaper?

15 MR. WHITELEY: No, no. What I was suggesting  
16 was if you affect only one level, in other words, the  
17 institutional buying level, and increased the costs to  
18 the institutions of that level, then you make, presumably,  
19 more attractive the purchase of imported lines which are  
20 not affected by the same circumstances?

21 MR. TURNBULL: No, Mr. Whiteley, I do not  
22 think so. I do not think we are attempting to say this.  
23 I think basically what we are attempting to say, although  
24 we do comment on this very problem, I think what we are  
25 basically attempting to say is if the price paid by the  
26 hospital is the right price, the other price must be  
27 wrong. If the price at which the Government is able to  
28 purchase drugs is the right price, the other two prices  
29 must be wrong. At the same time, if the retail price,  
30 the price at which the retail pharmacist buys a drug, is



1 correct, there must be something drastically wrong with  
2 the other prices.

3 THE CHAIRMAN: What you really mean - let's  
4 put it this way - the difference between what institutions  
5 pay and what the retail druggist pays is too great to be  
6 accounted for by cost saving or elimination of sales tax  
7 and other items; is that it?

8 MR. TURNBULL: Yes.

9 THE CHAIRMAN: Because if that is not the  
10 case, they might both be right.

11 MR. TURNBULL: Yes.

12 THE CHAIRMAN: What Mr. Whiteley is saying,  
13 as I understand it, if, as a result of this proposed  
14 change, you increase the price to institutions, are you  
15 not likely to cause those institutions to be more inclined  
16 to purchase from abroad from sources which are not affected  
17 by the change?

18 In other words, drugs obtained from abroad  
19 would be in a much more competitive position, much better  
20 able to compete with Canadian products on the basis of  
21 price?

22 MR. TURNBULL: I would not like to say that.  
23 I would not like to say they are in a better position to  
24 compete because I do not know.

25 THE CHAIRMAN: If the price on the Canadian  
26 products go up, and their price is not affected, it is  
27 almost automatic they are in a better position than they  
28 were before.

29 MR. TURNBULL: At the institutional level?

30 THE CHAIRMAN: Oh, yes.



1 MR. TURNBULL: Presumably, yes.

2 THE CHAIRMAN: What Mr. Whiteley's question  
3 is, have you considered what effect this might have on  
4 institutional buying from abroad?

5 MR. TURNBULL: Well, regrettably during the  
6 past year or so we have had to give an awful lot of  
7 consideration to the effect that what is going on is  
8 having on the opinion that the public and our legislators  
9 and others apparently have of prices at the retail level.

10 Regrettably, that is a very primary concern  
11 to the pharmacy practitioner today. It is extremely bad  
12 publicity, and apparently what I would choose to call  
13 erroneous thinking towards this whole subject, and a  
14 failure to acknowledge that institutions and possibly  
15 governments buy everything, and I suppose we should temper  
16 everything - almost everything - at prices that are very  
17 much lower than the individual private consumer pays for  
18 them at the retail level.

19 THE CHAIRMAN: They do buy sometimes from  
20 abroad even now, I suppose? Institutions do.

21 MR. TURNBULL: I presume so. I do not know.

22 THE CHAIRMAN: If the price from Canadian  
23 manufacturers went up, would they not be inclined to buy  
24 more from abroad?

25 MR. TURNBULL: Well, our only suggestion,  
26 sir, is that this is one area in which it would appear  
27 there is some element of solution to the problem which  
28 apparently has been erroneously considered by many people  
29 and has brought about some claim that prices of drugs in  
30 Canada are high.



1 I think we can use many examples. I know  
2 that our friend here has used examples of two cents  
3 versus the eighteen cents, I believe, of pricing differen-  
4 tial.

5 We can get into examples in other fields,  
6 of course, and I attempted to find the piece of paper,  
7 newspaper or the piece of public press that I read it in  
8 about two months ago where the Metropolitan Toronto Police Depart-  
9 ment had bought 55 automobiles for \$56,000. You and I,  
10 for the same 55 automobiles - or even one of those, it  
11 would cost, shall we say, three to four thousand dollars.  
12 This is a pricing differential in these various purchasing  
13 levels, there is an acknowledged difference in other  
14 lines, but obviously we are not prepared to acknowledge  
15 these things in the cost of drugs. We are therefore  
16 pointing out why some of these differences do occur, and  
17 at the same time our own premise that there should be one  
18 equal price for equal quantities.

19 No, we have not given consideration to this  
20 further problem because, as the Chairman points out,  
21 possibly institutions are buying drugs from foreign  
22 sources now. I do not know.

23 THE CHAIRMAN: As far as price being high  
24 is concerned, I do not think there has been any denial  
25 from the manufacturers we have had before us or from the  
26 Association that drug prices are higher in Canada than  
27 they are in European countries, or in Japan, and quite a  
28 number of reasons for that fact were given to us: the  
29 labour costs, cost of manufacture, lower cost of promotion,  
30 detailmen, distribution and so on. These things do lead



1 to their costs being lower than they are in Canada, which  
2 might mean with increase in cost to institutions there  
3 would be a greater tendency to import from abroad.

4 That is the point Mr. Whiteley was making,  
5 and it does seem to raise a point which would have to be  
6 considered if your proposal was to be put into effect,  
7 and see what the results might be. Sometimes results  
8 are not just exactly what you expect.

9 MR. TURNBULL: Yes. I think we certainly  
10 agree with that.

11 If the manufacturer - and this is really  
12 continuing on with what was said - were to make all sales  
13 of his product at prices equal to those tendered to hospi-  
14 tals and institutions, his fixed overhead cost would pro-  
15 bably never be recovered at his present volume of business.  
16 A single price policy with the only difference being due  
17 to economies realized through volume of purchase would  
18 result in an institutional price which would be somewhat  
19 higher and the price to retail pharmacies would be substan-  
20 tially lower. The formulary system in hospital institu-  
21 tions affords them an effective tool with which to reduce  
22 drug costs.

23 THE CHAIRMAN: I understand, Mr. Turnbull,  
24 your Association does not object to the formulary system  
25 in hospital institutions, but you said you do not think  
26 it would be satisfactory or useful if extended to the  
27 retail pharmacist level?

28 MR. TURNBULL: That is correct.

29 This, combined with buying by tender, gives  
30 two factors which greatly exaggerate the difference between





1 the cost of a similar drug to an institution and to a  
2 retail pharmacy, and has the effect of requiring the  
3 purchaser of pharmaceutical services through a retail  
4 pharmacy, to pay a disproportionately high percentage of  
5 the total drug bill.

6 Factors of Comparison - Government vs Retail Prices:

7 Canadian hospitals represent approximately  
8 25% of the drug purchasing power in Canada. The govern-  
9 ment purchases approximately 12.5%. There are many  
10 factors to be considered when one compares prices available  
11 to governments with prices paid by retail pharmacies for  
12 the same drugs.

- 13 1. It is not necessary to advertise or  
14 solicit government business, as tenders are  
15 automatically sent to all companies listed  
16 by the government. Hence, a company expe-  
17 riences considerable savings in administra-  
18 tive costs, selling and advertising.
  - 19 2. Governments usually buy in large quanti-  
20 ties.
  - 21 3. Large individual purchases eliminate  
22 speculative buying of raw materials and  
23 packaging equipment on the part of the manu-  
24 facturer.
  - 25 4. Government purchasing, presumably without  
26 any delivery time criterion, can be fitted in  
27 conveniently with production planning of the  
28 company to which the contract has been  
29 awarded.
- 30



L, MR/nm

1 5. Manufacturers, as corporate citizens,  
2 may well assume a responsibility and  
3 obligation to sell to governments at nominal  
4 costs.

5 THE CHAIRMAN: I am just a little puzzled  
6 by that; why manufacturers would assume the responsibility  
7 of doing that?

8 MR. TURNBULL: Possibly we should add that  
9 is being said with tongue-in-cheek.

10 THE CHAIRMAN: They may think this is good  
11 will.

12 MR. TURNBULL: Right.

13 THE CHAIRMAN: Rather than responsibility.

14 MR. TURNBULL:

15 6. The manufacturer who sells to a govern-  
16 ment purchaser is little concerned with the  
17 usual extensive handling, warehousing and  
18 accounting expenses involved in normal  
19 commerce.

20 7. Manufacturers, in making sales to  
21 government as well as to hospitals, are  
22 anxious to do so as a form of advertising  
23 so that the products of their manufacture  
24 appear in such institutions, thus being  
25 granted a degree of prestige while making  
26 their name better known to the practitioners  
27 involved.

28 8. In selling to governments, the manu-  
29 facturer directly compete with all manu-  
30 facturers of similar chemical entities.



1 MR. WHITELEY: Just before you go on, I  
2 don't think any of these points that you list here really  
3 come to bear on the effect of quantity purchases, which  
4 I took was the main criterion you were going to use as to  
5 any differences in prices.

6 MR. TURNBULL: This is a lead-in, sir,  
7 on the factors of comparison of government versus retail  
8 prices and I think that it is pertinent to the Commission  
9 in view of the quotation in the public press of the prices  
10 being paid by governments in purchasing drugs, presumably,  
11 of similar chemical entity to drugs available at the  
12 retail level.

13 MR. WHITELEY: Oh, I wasn't questioning  
14 its relevancy. I think it is quite relevant. Apart from  
15 number 2 I don't see how any of these factors could be  
16 points on a strictly quantity basis.

17 MR. TURNBULL: Not number 3?

18 MR. WHITELEY: Even that I assume that you  
19 are considering quantities which single individual  
20 pharmacists could purchase and it is hard to say how a  
21 purchase by one pharmacist could have any effect on the  
22 manufacturer's speculative buying of raw material.

23 MR. TURNBULL: Well the purchase by one  
24 Government could have quite a bearing on the manufacturer's  
25 buying of raw materials and setting up of the equipment.

26 MR. WHITELEY: Yes, I see that. I don't  
27 see how you work this out on a quantity price schedule.

28 MR. TURNBULL: We are commenting on existing  
29 conditions.

30 MR. WHITELEY: And I assume they would



1 continue.

2 MR. TURNBULL: Well I thought maybe you were  
3 referring to our single price policy of a few moments ago.

4 MR. WHITELEY: I thought that was what you  
5 were leading up to: There should be a change in the present  
6 pricing methods. This change should be based on quantity  
7 purchase.

8 MR. TURNBULL: Not necessarily.

9 MR. WHITELEY: There are other factors that  
10 you are going to suggest.

11 MR. TURNBULL: Not necessarily leading up  
12 to that.

13 It is suspected that there are many costs  
14 involved in government and institutional purchasing which  
15 are not made fully known and which are not accounted for  
16 when questions related to the cost of drugs are answered.  
17 It is agreed, however, that such costing would be intricate  
18 and would possibly serve no great purpose other than to  
19 clarify a degree of erroneous thinking when comparing  
20 prices. Some of these procedures and factors affecting  
21 such drug purchases are discussed here, although the  
22 Association does not presume to be fully conversant with  
23 the intricacies of government procedure.

24 It is presumed that the purchase of drugs  
25 is based on minimum inventory levels established through  
26 normal usage experienced by the various departments such as  
27 the Department of National Health and Welfare, the  
28 Department of Veterans Affairs and the Department of  
29 Defence Production. It is understood that most departments  
30 purchase for their own use, according to requirements



1 determined by medical staffs and pharmaceutical committees,  
2 and that the principal interest rests with price relative  
3 to products for which specifications have been laid down.  
4 It is presumed that much time, money and a great number of  
5 personnel are involved in purchase procedures:  
6 (a) Requisitions are forwarded to a headquarters office and,  
7 if approved, the necessary orders are prepared which describe  
8 the drugs and their specifications; (b) A purchasing office  
9 reviews the order and prepares a tender which is forwarded  
10 to a list of firms known to be suppliers of the drug  
11 required; (c) Prior to the closing date, any sealed tenders  
12 received are stored under supervised conditions for future  
13 tabulation and review; (d) After the letting of a contract  
14 to the firm which quotes the lowest price, inspection and  
15 testing is undertaken by inspectors who also subject samples  
16 of the delivered product to inspection; (d) If a product  
17 does not stand up to prescribed tests, further sampling is  
18 undertaken and if other failures are noted, the contract  
19 is subject to cancellation and the next lowest tender  
20 accepted. Where a drug may not be available from more  
21 than one company, a contract may be let on a cost-plus-  
22 percentage profit basis.

23                   Where small amounts may be required,  
24 purchasing is carried out by district offices to expedite  
25 delivery, with no great magnitude of financial outlay  
26 being involved. Here, time is of greatest importance as  
27 contract procedures might involve upwards of two months.  
28 However, drugs available to meet immediate demands are  
29 normally those of companies of known reputation and,  
30 therefore, inspection procedures may not be deemed necessary.





1                   As mentioned before, it is not known how  
2 costly these procedures can be, nor is it known (1) what  
3 personnel are involved, both in number and qualification;  
4 (2) what offices or office space may be involved; (3)  
5 what man hours, time and actual dollars might be involved;  
6 (4) what shipping, storage, re-packaging expenses are  
7 involved; (5) how many times contracts may be let to  
8 companies of unknown reputation which are later found to  
9 be not qualified to produce the drug; (6) how many times  
10 orders have had to await the development of "know-how"  
11 by the company which receives a contract; (7) how many  
12 times supplementary purchases from the original manufacturer  
13 had to be made while awaiting delivery from a contractor;  
14 (8) how many rejections have had to be made by the  
15 extensive inspection services relative to drugs produced  
16 by little-known companies, as compared with the production  
17 of the same drug under a known brand name; (9) how often,  
18 in spite of specifications and testing, poor quality drugs  
19 and drug preparations are supplied to regional hospitals  
20 and units.

21                   There exists no common basis for comparing  
22 drugs purchased and/or drug prices paid by governments  
23 with these involved in the rendering of pharmaceutical  
24 services by private practitioners in community locations.  
25 The Association questions the correctness of any attempts  
26 which have been made to establish areas of comparison on  
27 strict cost bases, only.

28                   THE CHAIRMAN: I was wondering, Mr. Turnbull,  
29 in this list of nine where the cost is unknown would the  
30 later building up of a list of costs which these institutions



1 pay, which they might not pay if they were purchasing --

2 MR. TURNBULL: The section refers to  
3 government purchases, sir.

4 THE CHAIRMAN: I know. I mean government  
5 institutions, government departments. Are you indicating  
6 that there are a lot of hidden costs in government purchases  
7 which would not exist if they purchased them in some other  
8 way?

9 MR. TURNBULL: We are indicating sir that  
10 the prices quoted to government enquirers, or prices paid  
11 by the government for drugs have been erroneously quoted  
12 in that they do not take into account all the expenses  
13 involved in these many expenditures, and therefore they  
14 painted an extremely disadvantageous picture in relating  
15 the cost of drugs paid by the Government as compared to  
16 the cost of drugs paid by the consumer at the private level.

17 THE CHAIRMAN: Wouldn't lots of these costs  
18 be incurred, or many of them be incurred no matter what  
19 system of purchasing the Government department had?

20 MR. TURNBULL: Yes, we think so. Why should  
21 they not be acknowledged?

22 THE CHAIRMAN: The total cost to the  
23 Government department may be higher than the price they  
24 pay the manufacturer all right, but that is something which  
25 is probably the case if they bought at a different price.  
26 I am just trying to see what the purpose is of this series  
27 of costs which you have outlined. How does that affect  
28 the question whether the Government departments pay too much  
29 or too little to the manufacturer?

30 MR. TURNBULL: That has not entered into this



1 discussion. This discussion merely relates to the signi-  
2 ficance of the figures quoted upon enquiry of the cost  
3 for a drug to a Government as opposed to the figures that  
4 supposedly pertain to the cost of that same drug at the  
5 retail or other level purchase.

6 But all of these factors which are costly  
7 in terms of actual dollars, in effort and office space,  
8 overhead, and all have never been recognized as part of  
9 the quotation given when referring to the costs paid by  
10 Government for their drugs.

11 THE CHAIRMAN: Which means the total costs  
12 to Government are substantially higher than the prices they  
13 pay?

14 MR. TURNBULL: Than the prices they have  
15 made known, yes, as having been paid, yes.

16 THE CHAIRMAN: Assuming that those are the  
17 prices they pay?

18 MR. TURNBULL: Yes.

19 THE CHAIRMAN: Their total costs are higher  
20 which is not the case of the individual buying from a retail  
21 store. The price they pay is the cost?

22 MR. TURNBULL: Yes.

23 THE WHOLESALE DRUG TRADE

24 The pharmacists of Canada rely heavily  
25 upon wholesale drug outlets which provide ready, convenient  
26 access to a huge variety stock of items too numerous, and  
27 often too expensive to be carried in quantity. These same  
28 wholesale houses enable manufacturers to place quantities  
29 of their products in every major centre of our vast nation  
30 so that they are available without dealy and without heavy



1 transportation costs. Some manufacturers have district  
2 warehouses, some sell only through wholesalers, while still  
3 others have facilities and policies whereby their products  
4 are available direct or from branches or from wholesalers.  
5 prices are usually different at each buying source.

6 Wholesale drug operations are discussed in  
7 the Director's Statement from the point of view of  
8 popularity and success, or otherwise, due to price and  
9 discount policies. It is suggested that the shareholder  
10 rebates discussed in paragraph 456 are more widespread than  
11 those mentioned in the Director's Statement, in that in many  
12 parts of the country, similar purchasing agreements are in  
13 effect to assist the retail pharmacist.

14 THE CHAIRMAN: Mr. Turnbull, it is half  
15 past twelve and the next section, Retail Pharmacy in Canada,  
16 is quite a lengthy section, is it not?

17 MR. TURNBULL: Yes.

18 THE CHAIRMAN: I think perhaps we had  
19 better adjourn. This is approximately the time we adjourn  
20 anyway. We will adjourn until two o'clock.

21  
22 ---Luncheon adjournment.

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LA. /dpw

1 --- On resuming at 2 p.m.

2 MR. TURNBULL: RETAIL PHARMACY IN CANADA.

3 Pharmacy is an ancient profession. The fact that it is  
4 customarily practised as a part of a retail business  
5 establishment has brought about certain conflicts between  
6 scientific requirements, professional ethics, and the  
7 desire -- in fact, the need -- to make a profit.

8 Seen in its entirety, pharmacy is a conglo-  
9 meration of diverse interests. In particular, the  
10 interests of the pharmacist as a profit-seeking retailer  
11 and the pharmacist as a professional technician are  
12 frequently in conflict. From the beginning of Canadian  
13 pharmacy the pharmacist -- or druggist, as he was more  
14 commonly known -- has engaged in merchandising of a  
15 variety of related commodities. There is no question  
16 that the manifold merchandising activities in which most  
17 pharmacists engage today are honourable and that the  
18 function of distribution is as important as any other in  
19 the economy of our society. As a consequence, and because  
20 only in a minority of businesses has commerce in medici-  
21 nals been sufficient for the successful maintenance of a  
22 strictly professional pharmacy, the drug store has evolved,  
23 under the conditions of a free enterprise economy, to its  
24 present stage. In modern times, the range of its commer-  
25 cial undertakings has been extended within variable limits  
26 but with a concurrent effort to always provide necessary  
27 professional service to its community.

28 THE CHAIRMAN: Mr. Turnbull, with regard to  
29 that last statement, I think that undoubtedly is generally  
30 true. There have been some examples of pharmacies in





1 which the proliferation of articles offered for sale have  
2 been of such a manner they make you wonder how much atten-  
3 tion is being paid to the strictly pharmaceutical aspect  
4 of the business. That is the impression I have got. I  
5 don't know whether your Association would agree there are  
6 examples of that kind?

7 MR. TURNBULL: We wouldn't disagree with  
8 that, sir.

9 THE CHAIRMAN: I can think of an example  
10 in Winnipeg. I made the comment I had seen so many kinds  
11 of different items in a drugstore, the only thing I  
12 hadn't seen was fresh meat. They told me I could go to  
13 North Winnipeg and I would find a number of cases where  
14 fresh meat was being sold in pharmacies.

15 MR. TURNBULL: I have never seen such  
16 examples myself. I think you will readily acknowledge  
17 that is the exception, not the rule.

18 THE CHAIRMAN: Oh yes, but there is a great  
19 variety of things that are sold in what you might call a  
20 standard, normal pharmacy, and then in some there is a  
21 large amount of floorspace and a good deal of advertising  
22 and a great variety of things that couldn't be called  
23 related to pharmaceutical activities, either direct or  
24 indirect.

25 MR. TURNBULL: There are instances.

26 THE CHAIRMAN: What you see, practically  
27 speaking, is a department store or large variety store  
28 with a pharmacy department.

29 MR. TURNBULL: Pharmacy is the primary pur-  
30 pose.



1 THE CHAIRMAN: I hope it is the primary  
2 purpose. I sometimes wonder, with the amount of space  
3 taken up with other things.

4 MR. TURNBULL: Scientific progress and  
5 economic changes during these post-war years are serving  
6 both to expand and to rearrange the structure of pharmacy.  
7 It is a very common misconception, however, that, because  
8 it no longer is necessary for the pharmacist to personally  
9 prepare and purify his medicaments from crude drugs and to  
10 compound them into special prescription form, his work  
11 has been greatly simplified. On the contrary, the  
12 increasing complexity of modern medication, problems of  
13 stability and the resultant opportunity and, in fact, the  
14 need for pharmacists to become "clearing houses" of infor-  
15 mation on medicines continues to demand more and more  
16 knowledge to the point where the role of the pharmacist  
17 is becoming dependent not so much on what he does as on  
18 what he knows -- a consultant on matters pertaining to  
19 drugs. With these changes the scope of scientific know-  
20 ledge required by the pharmacist has expanded, and his  
21 opportunities for application of professional abilities  
22 have increased in number, though changed in form.

23 It must be recognized that the forces  
24 directly determining the professional status of pharmacy  
25 operate from outside rather than from inside the colleges  
26 and schools of pharmacy. Pharmacy has taken a long time  
27 to come to its present state of practice. However, the  
28 past several months have clearly demonstrated that there  
29 is a regrettable tendency on the part of a not inconside-  
30 rable segment of the public to regard the present-day



1 pharmacist of the neighbourhood drugstore as one whose  
2 service requires no very great amount of specialized  
3 scientific knowledge and skill. True it is that the  
4 individual pharmacist has become less a compounder of  
5 medicines and more a scientific purveyor and technical  
6 adviser. Specialization in various phases of pharmacy is  
7 increasing as it is in many other technical and professio-  
8 nal activities. Furthermore, the pharmacist of today must  
9 reckon with the highly organized and specialized distri-  
10 butive agencies. All this has created a new economic  
11 environment within which pharmacy is mostly practised.

12           Because pharmacy practice is predominantly  
13 retail, the major activities of its national Association  
14 pertain to matters which come to the notice of 'drugstore'  
15 owners and managers. The Association, however, has  
16 seldom been inclined towards a professional, selfish self-  
17 interest. A review of the many debates at annual meetings  
18 which are now history, substantiates that Canadian Phar-  
19 macy's leaders have always been greatly concerned with  
20 matters of general public interest in the health field.  
21 Indeed, the profession has best served Canada by its insis-  
22 tence that the public be adequately protected through  
23 legislation, where necessary, which stipulates the pharma-  
24 cist's role in safeguarding drugs and other therapeutic  
25 items and how such will be distributed and marketed.

26           From the retail viewpoint, Pharmacy is not  
27 'big business'. Bigness has come about in the form of a  
28 few chain operations, but they are limited in number (some  
29 431 stores in 39 companies). Approximately 90% of the 4900  
30 total are, generally speaking, individually owned and



1 operated pharmacies.

2 THE CHAIRMAN: Mr. Turnbull, do you know any  
3 trend at all developing that might lead to any change in  
4 that situation? I am thinking I remember a chain of drug-  
5 stores when I was a very small boy. That small chain was  
6 acquired by Liggett's, and then Tamblyn's, and one or two  
7 others since have come. I have had the impression there  
8 really are not any more chain store operations than there  
9 were 50 years ago, the pharmacists in general, the great  
10 majority wishes to operate their own premises and not be  
11 employed as part of a large chain.

12 MR. TURNBULL: I think proportionately  
13 speaking that is correct. There is a possibility a few  
14 more stores and pharmacists are involved as part of a  
15 chain, but as a proportion of the total I don't think  
16 they have increased. As you mentioned some are bought up  
17 by larger chains to expand their chain, consequently there  
18 is no real expansion.

19 THE CHAIRMAN: You don't see anything like  
20 what took place in the grocery field? You don't see any  
21 signs of that?

22 MR. TURNBULL: No. Possibly I should amplify  
23 where I stated individually owned and operated pharmacies.  
24 I am also referring to those that are operated as limited  
25 companies but are essentially under the direct ownership  
26 - under the direct managership of the principal owner, who  
27 is a pharmacist. There are certain pieces of legislation  
28 in some of the Provinces that relate definitely to this  
29 same aspect.

30 All offer, in addition to the professional





1 prescription items and service, a wide variety of brand  
2 name patent medicines and sundries. Many distribute,  
3 under dealer franchises, specialty packaged goods under  
4 labels such as Rexall, I.D.A. and others. In many cities,  
5 with costs beyond the resources of the individual, co-ope-  
6 rative advertising in newspapers and on the air is used  
7 to enable pharmacies to competitively promote their  
8 services in the community.

9           The retail pharmacist, operating under high  
10 overhead costs not common to other retailers, has a parti-  
11 cular stake in good business policies. Contrary to some  
12 popular thinking, he has no monopoly except those that  
13 accrue from the professional responsibilities he has  
14 chosen to accept over the items and preparations which  
15 legislation has placed within his control. Professional  
16 licensing is available to him only after some four years  
17 of academic study in one of the eight Canadian universi-  
18 ties which have Colleges of Pharmacy.

19           The C.Ph.A., as a federation of licensing  
20 bodies is, and must continue to be vitally interested in  
21 standards of practice, including ethics, in the assumption  
22 of legal and moral obligations. Since 1240 A.D., when it  
23 was first decreed that medicine and pharmacy should be  
24 practised as separate professions, a long process of evo-  
25 lution has determined those practices that are wise and  
26 equitable in the matter of the safe distribution of drugs.  
27 Governments, to an increasing degree, have delegated  
28 responsibilities and safeguarding duties to pharmacists  
29 and have placed the responsibility on pharmacy licensing  
30 bodies to supervise and enforce their regulations.





1 As an Association, we are convinced that  
2 what has evolved is a system that is providing a maximum  
3 amount of public protection at a minimum of enforcement  
4 cost to Governments and at a not unreasonable overall cost  
5 to the general public.

6 In striving to provide guidance to its  
7 member associations in the matter of high standards of  
8 practice, the C.Ph.A., from time to time, has drawn the  
9 Federal Government's attention to the danger of loss-leader  
10 selling in relation to the maintenance of such high stan-  
11 dards. We have been encouraged, therefore, by the 1960  
12 amendments to Combines legislation which acknowledge cer-  
13 tain needs in the field of orderly marketing.

14 THE CHAIRMAN: It is not in our Terms of  
15 Reference, but when you refer to loss-leader as defined  
16 in the Combines Act, have you in the field of pharmacy  
17 run across many instances with loss-leader activities  
18 within the terms of the Combines Act?

19 MR. TURNBULL: Within the field of pharmacy,  
20 retail pharmacy practice itself, no sir.

21 THE CHAIRMAN: What is the danger you are  
22 concerned about?

23 MR. TURNBULL: Canadian pharmacy, Canadian  
24 retail pharmacy through the National Association; namely,  
25 the Canadian Pharmaceutical Association are, of course,  
26 vitally interested in all matters which may have a bearing  
27 either at the present time or at some future time on  
28 matters related to or contributing towards the standards  
29 of practice, pharmaceutical practice. We recognize in our  
30 activities that many of the pharmacy practitioners are in



1 retail establishments merchandising items that are also  
2 merchandised by many other retail establishments and the  
3 influence of merchandising practices carried out by these  
4 other outlets are definitely going to have an influence  
5 upon some future practices of some of the retail pharma-  
6 cies. If these are carried to a point to which they might  
7 endanger the standards of pharmaceutical practice then we  
8 must do everything possible to forestall such activities.

9 THE CHAIRMAN: Are you thinking of things  
10 like supermarkets?

11 MR. TURNBULL: Well, I am thinking more  
12 here, in our discussion here, sir, of the overall picture.  
13 I suppose that supermarkets get into this, and what we  
14 commonly call discount operations, discount stores, cut-  
15 rate operations that do handle patent medicines, sundries,  
16 and it was mentioned here earlier today, camera supplies,  
17 that type of thing that is handled in retail pharmacies  
18 as part of their business.

19 THE CHAIRMAN: I was wondering would they  
20 run across any instances of serious concern in the matter  
21 of actual loss-leadering?

22 MR. TURNBULL: I wouldn't attempt to quote  
23 any instances.

24 THE CHAIRMAN: The term is being used a  
25 little loosely. I didn't know whether you had anything  
26 definite in mind.

27

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JW/nm

1 MR. TURNBULL: I think possibly we can  
2 bring forth that, if you so wish.

3 THE CHAIRMAN: No, I don't think it is of  
4 any great importance at the present time. If it is a  
5 problem that you saw as serious at the present time, it  
6 might have some effect and it might be of some interest to  
7 us to know about it.

8 MR. TURNBULL: It is a problem that we must,  
9 I believe, view with a high degree of seriousness if it  
10 is going to have some overall effect either now or in the  
11 future upon the rendering of pharmaceutical services.

12 THE CHAIRMAN: I take it from what you said  
13 you are more concerned about what may happen than what  
14 has happened.

15 MR. TURNBULL: That is correct.

16 We reiterate here that actions on the part  
17 of individual pharmacists incompatible with this principle  
18 can lead only in the direction of a general lowering of  
19 standards. Any tendency toward the lowering of standards  
20 will be resisted by organized Pharmacy. They would not  
21 be compatible with pharmacy's current efforts towards the  
22 instigation of minimum standards of pharmaceutical practice  
23 as well as a national examining board in pharmacy. Lowered  
24 standards should not be tolerated by the public.

25 "Why the variety of general merchandise in the  
26 drugstore?", is a frequent question. The answer, briefly  
27 stated, is that those items subsidize prescriptions and  
28 make the availability of pharmaceutical service financially  
29 practical in our communities. Prescription service requires  
30 a heavy inventory of expensive drugs which must be stocked



1 to answer the needs of a multitude of physicians'  
2 individual diagnoses and patients' symptoms. Definite  
3 figures are impossible to obtain, but it can be safely  
4 stated that a retail pharmacy which dispenses between 40  
5 and 50 prescriptions daily will stock 3500 drugs and drug  
6 preparations of various dosage forms and potencies valued  
7 at approximately \$7,000, and representing some 35% of the  
8 total inventory value of all items carried. Not all agree  
9 that unrelated merchandise should be offered for sale  
10 in Canadian pharmacies. Indeed, the challenges which such  
11 merchandising offers have resulted in the pharmacist  
12 allowing himself to be unduly influenced by many  
13 merchandisers who do not have the best interest of pharmacy  
14 practice at heart. However, such pros and cons will not  
15 be debated here.

16               The 'average' Canadian retail pharmacy  
17 reporting to the Association's annual survey had, in 1960,  
18 a sales volume of \$106,688. There are approximately  
19 4900 retail pharmacies in Canada and Canadian consumers  
20 spent, that year, 1960, slightly over one-half of one  
21 billion dollars in them. Prescription receipts accounted  
22 for 25% of this, (26% in 1959) with 42,840,810 prescrip-  
23 tions being dispensed at an average cost of \$3.06 (an  
24 increase of eight cents on the average of the 43,916,605  
25 dispensed in 1959). The average pharmacy dispensed  
26 8,846 prescriptions (24 per day).

27               Overall sales produced a gross margin of  
28 33.4% at a cost of 28.4% for a net profit figures of  
29 5.0% from an inventory of \$20,335 which turned over 3.5  
30 times.



1 THE CHAIRMAN: There is a point there. I  
2 am not quite sure how those figures were arrived at. In  
3 the previous paragraph you refer to a sales volume average  
4 of \$106,000- odd and now you speak of overall sales for  
5 a net profit figure of 5% from an inventory of \$20,335.  
6 which turned over 3.5 times. Three and a half times  
7 \$20,000. would be \$70,000. Are these figures the same  
8 thing?

9 MR. TURNBULL: The overall sales produced  
10 a net profit figures of 5%, and this came from an average  
11 inventory of \$20,335. It had a turnover rate of 3.5 times.  
12 This 5% is based on gross sales.

13 THE CHAIRMAN: On an inventory of \$20,000.,  
14 turning over  $3\frac{1}{2}$  times would make total sales of a little  
15 over \$70,000., not \$106,000.

16 MR. TURNBULL: The inventory, of course,  
17 was at cost price which would be a little over \$70,000.  
18 for a gross margin of some 33.4%. 33.4% of \$106,000 is  
19 a little more than \$35,000. which, taken off \$106,000 would  
20 be about \$71,000.

21 THE CHAIRMAN: It would be very close to  
22 that.

23 MR. TURNBULL: Yes.

24 THE CHAIRMAN: This is the cost price and  
25 the other is selling price?

26 MR. TURNBULL: Right.

27 Wages, the highest single expense, at \$10,562  
28 provided employment for at least one pharmacist other than  
29 the proprietor. Investment in inventory, fixtures and  
30 accounts receivable was in excess of \$29,000.





1                   The foregoing figures are quoted directly  
2 from the Association's 19th Annual Survey of Canadian  
3 Retail Pharmacy Operations as published in the 'Canadian  
4 Pharmaceutical Journal', Volume 94, No. 9, September,  
5 1961, (extracted and included herewith as an Exhibit).

6                   May I, Mr. Chairman, present this extract  
7 as an exhibit?

8                   THE CHAIRMAN: Exhibit T-16.

9  
10       ---EXHIBIT T-16:                   Extract from 'Canadian  
11    Pharmaceutical Journal'  
12    Volume 94, No. 9, September  
13    1961, 19th annual survey  
14    of Canadian Retail  
15    Pharmacy Operations.

16                   MR. TURNBULL: This statistical compilation  
17 of financial information, voluntarily supplied by means of  
18 a mailed questionnaire, has been conducted for the  
19 Association annually since 1952 by Professor H. J. Fuller  
20 who is Professor of Pharmacy Administration of the  
21 University of Toronto's Faculty of Pharmacy.

22                   In 1960 'average' figures relate to 664  
23 pharmacies, and is thus a sampling of one out of every  
24 eight pharmacies in Canada. One survey will differ from  
25 another, it is true, but the Association chooses to rely  
26 upon and quote from figures arising from its internal  
27 service work because it is most familiar with it and its  
28 degree of continuity of sample, as opposed to excellent  
29 information arising from the less-familiar publications of  
30 the Dominion Bureau of Statistics. The fallacy of viewing  
\$106,688 as an 'average' sales volume is illustrated by  
the facts that of the 664 pharmacies in the survey, 406



1 (or 61.1%) had sales below \$106,688, and further that:

2 11.1% below \$ 50,000

3 23.8% \$ 50,000 - \$ 75,000

4 22.6% \$ 75,000 - \$100,000

5 28.9% \$100,000 - \$150,000

6 13.6% Over \$150,000

7 46.4%, or almost one-half, realized a total

8 sales volume in the \$50,000 - \$100,000 range. There has

9 been an improved picture in the below \$50,000 category

10 during the years since 1954, with the number decreasing

11 from 27.9% in 1955 to 11.1% in 1960. The sales range,

12 \$50,000 - \$75,000 has remained stable in comparison with

13 other ranges in that during the 6-year period, 1955-1960 in-

14 clusive, it has contained pharmacies representing 44.5%,

15 44%, 46%, 45.9%, 47.9% and 46.4% respectively, of the

16 total number reporting to the survey.

17 In considering averages, it is significant

18 to note that the average total income of \$14,662 which

19 includes all revenue from net profit, unrelated sales

20 and proprietor's salary, was founded to be unrealistic in

21 that the greatest percentage, namely 13.7% who answered

22 the survey were in the \$12,000 - \$12,999 range. 69.3%

23 'enjoyed' total income of less than the survey average.

24 40.5% realized net profits below the survey average of 5.0%.

25 Of the 664 pharmacies surveyed, 312 are

26 identical pharmacies which are known to have reported at

27 least during the last two successive years. From these it

28 is noted that sales increased by \$4,150, while prescription

29 volume declined, per pharmacy, by about 9 per week. Such

30 a decline, although hardly noticed by the individual



1 pharmacy, readily shows in a survey of this nature, and  
2 Professor Fuller comments, "Whether there was less sickness  
3 requiring prescribed medicines in 1960, whether there was  
4 just as much sickness but more people received their  
5 prescribed medicine in hospitals as a result of the various  
6 hospital insurance plans throughout Canada, or whether  
7 physicians wrote fewer prescriptions as a result of the  
8 unfavourable newspaper publicity given to prescriptions and  
9 governmental investigations into the cost of drugs, is  
10 not clear."

11 THE CHAIRMAN: In other words we have no  
12 evidence from which to draw any conclusion as to the  
13 cause of this reduction.

14 MR. TURNBULL:

15 Using D.B.S. figures of December, 1958 in  
16 which it is stated that 2.43¢ of the consumer dollar was  
17 spent in Canadian pharmacy and applying this to our survey,  
18 prescription services take up about only 3/5 of 1¢ of the  
19 consumer's buying dollar. Further, it is indicated that,  
20 during 1960, per capita expenditure on prescriptions  
21 amounted to \$7.36.

22 In the light of current investment returns  
23 and interest rates on borrowed money, a 5.0% net profit  
24 for a retail pharmacy is indeed slim.

25 MR. WHITELEY: How do you arrive at that  
26 opinion?

27 MR. TURNBULL: I think the statement is  
28 made, Mr. Whiteley, in the light of current investment  
29 returns and interest rates on borrowed money. The invest-  
30 ment which I think is expanded a little bit later in this



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1 presentation, the investment required to, shall we say,  
2 open a pharmacy, or the young man who has come out of a  
3 university after quite a heavy expenditure on his education,  
4 and the money that he invests in creating and keeping a  
5 business going as compared to the financial return he  
6 might receive from investing that same amount of money and  
7 getting out and working in some other operation, but on  
8 the average I believe it would be acknowledged that five  
9 per cent interest is not an exceedingly high rate of  
10 interest.

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1 MR. WHITELEY: Not 5% interest; 5% net  
2 profit on sales?

3 MR. TURNBULL: That is correct.

4 MR. WHITELEY: What does that represent in  
5 terms of return on investment?

6 MR. TURNBULL: I have no figures on this.  
7 I could do so.

8 MR. WHITELEY: Then how do you arrive at  
9 this opinion if you haven't related it to the investment?

10 MR. TURNBULL: It is related in general  
11 terms only.

12 MR. WHITELEY: Does it represent 10% return  
13 on investment or something less than that or something  
14 more?

15 MR. TURNBULL: I have not those figures.

16 THE CHAIRMAN: Of course there are other  
17 monies invested besides that in inventory. You are compa-  
18 ring it with rates of return on business annually?

19 MR. TURNBULL: Yes.

20 THE CHAIRMAN: But 5% is on sales. It may  
21 have little or no connection with annual return on invest-  
22 ment. If your sales amount to twice as much as your  
23 capital investment, your 5% on sales would be 10% - if you  
24 sold twice as much in a year compared with capital invest-  
25 ment and make 5% on sales net --

26 MR. TURNBULL: Yes.

27 THE CHAIRMAN: That is the same as 10% on  
28 your capital investment?

29 MR. TURNBULL: Yes. Our reference here, of  
30 course, in a general statement of this nature must relate





1 to the original figure of \$106,688, and it is based on the  
2 financial interest to be gained from such an investment of  
3 that amount of money, which presumably could be available  
4 to the man who is working without financial investment in  
5 another operation that was investing money available to  
6 him; the same amount of money in a hypothetical case.

7 THE CHAIRMAN: What is the amount of the  
8 investment? It is not the one hundred and six thousand.  
9 That is the sales.

10 MR. TURNBULL: Well, our reference here is  
11 to that \$106,000. Comparable return. We are not sugges-  
12 ting in here that \$106,000 has been invested in the busi-  
13 ness. We are relating the profit on \$106,000 as opposed  
14 to the possible financial return available on \$106,000.

15 THE CHAIRMAN: That is the point. You are  
16 comparing a return on sales in this industry with return  
17 on investment in some other industry, and the two are not  
18 comparable.

19 MR. TURNBULL: That is our basis of compari-  
20 son here.

21 THE CHAIRMAN: One is return on investment,  
22 and the other one is not?

23 MR. TURNBULL: That is our basis of compari-  
24 son here. If it is deemed incorrect ---

25 MR. WHITELEY: The return of 5% on \$106,000  
26 is five thousand-odd.

27 MR. TURNBULL: That is correct.

28 MR. WHITELEY: Well, the thing is what invest-  
29 ment you need to produce that \$5,000. What return you  
30 could get if you took that same investment and put it in



1 some other industry. Would you get more or less?

2 MR. TURNBULL: We have not attempted to  
3 work on that basis here.

4 MR. WHITELEY: Then it seems to me to draw  
5 the conclusion that the return is slim, cannot be done  
6 until you have made that comparison. It may not be. It  
7 may be a good return.

8 MR. TURNBULL: That is correct.

9 MR. WHITELEY: You might wish to supplement  
10 on that point.

11 MR. TURNBULL: All right.

12 THE CHAIRMAN: If you have figures on the  
13 average investment. All right, proceed.

14 MR. TURNBULL: If, referring back to our  
15 previous questions, 'other merchandise' were to disappear  
16 from drugstore operations, would pharmacy services remain  
17 in our communities, (that is 675 communities are served  
18 by only one pharmacy), or conversely, could the public  
19 tolerate the necessary increase in prescription prices to  
20 cover the static overhead? Limitation to professional  
21 service items might be desirable but such is impractical  
22 in our free enterprise system.

23 Academically, the theory could be advanced  
24 that a one-man pharmacy serving a population of some 3600  
25 people could survive on the assumption that such a popula-  
26 tion would also be served by four medical practitioners,  
27 each theoretically writing 5 prescriptions each day of a  
28 five-day week, thus creating 5200 new prescriptions per  
29 year, plus a probable repeat number totalling 3000. Then,  
30 assuming figures from the table presented in the C.Ph.A.'s



1 19th Annual Survey based on the various quoted averages,  
2 the pharmacy might realize a total income, including all  
3 salaries and wages, in the neighbourhood of \$8800.

4 Needless to say, this would work in theory only, as such  
5 a small return on investment, education, time and effort  
6 makes it highly impractical.

7                   An independent review by Professor H.J.  
8 Fuller of the Faculty of Pharmacy, University of Toronto,  
9 of 42,545 prescriptions from 182 pharmacies in November,  
10 1957, revealed that 46% were dispensed at a loss below an  
11 average breakeven cost of \$1.72! It showed, too, that  
12 88.6% of all prescriptions are priced at below \$5, while  
13 1.1% were over \$10. This Canadian Prescription Survey  
14 showed great evidence of erratic pricing methods.

15                   In the following table, in 50¢ price inter-  
16 vals, prices are shown against an average breakeven cost  
17 (cost of ingredients plus container - 10¢; labour appli-  
18 cable - 56¢; and overhead cost - 25¢).

19                   THE CHAIRMAN: Mr. Turnbull, is there any  
20 way you can give us any indication of how these items of  
21 10¢, 56¢ and 25¢ were arrived at?

22                   MR. TURNBULL: It would be very difficult  
23 to arrive at this, sir, but there was an extensive and  
24 expensive, by the way, time and motion study carried out  
25 in the United States back in 1955. This was written up  
26 in the Journal of the American Pharmaceutical Association  
27 under the editorship or authorship of Jeffries and Gold-  
28 berg of the Brooklyn College of Pharmacy, and they used  
29 figures of \$4.20 per hour applicable to the pharmacist's  
30 service, and related that at 7¢ a minute, some 8 minutes



1 on the average for the filling of a prescription, to a  
2 56¢ total.

3 Now, I think it can be argued that these  
4 figures might not necessarily apply to the Canadian scene,  
5 but they were the only ones available, and they were not  
6 unreasonable figures to be used. That is the figure that  
7 was supplied there in the labour of 56¢.

8 THE CHAIRMAN: I was thinking in relation  
9 to the time that has gone on, the multiplicity of prepared  
10 dosage forms, the time for each prescription might be less  
11 than 7 or 8 minutes.

12 MR. TURNBULL: I don't believe so, sir. I  
13 think we can figure this out. I briefly calculated it  
14 from my own personal experience, which I indicated of  
15 course was a few years ago when I was in one of the larger  
16 Saskatoon dispensaries where we did anywhere from 200 to  
17 300 prescriptions in the course of a day; five pharmacists  
18 dispensing 250 prescriptions, shall we say.

19 We opened the pharmacy at 8 in the morning;  
20 we spent the morning doing any stock replenishing and pre-  
21 use compounding that we thought was going to be necessary  
22 to meet prescription needs during the course of that day,  
23 and we spent a very busy afternoon in the running of  
24 patient services, and then spent one to one-and-a-half  
25 hours after the 6 o'clock time when everyone else had  
26 left tidying up our papers, filling out Government forms  
27 and this type of thing. In essence you have a 12-hour  
28 day with five pharmacists working, and it breaks down to  
29 about 7 or 8 minutes for the handling of a prescription in  
30 the overall average of the day.



1 THE CHAIRMAN: I am not saying it is not  
2 necessary, but it seems to me with the growing number of  
3 prescription items which come already prepared so far as  
4 size and that is concerned, a great many of them, it  
5 takes less time than was the case where the pharmacist  
6 had to do the actual compounding himself. If those items  
7 increased proportionately, would you think there would be  
8 less average time?

9 MR. TURNBULL: Not necessarily, sir. The  
10 degree of responsibility that must be applied against  
11 each and every prescription is time-consuming, and that  
12 time is still there regardless of the nature of the  
13 prescription, the physical part of the prescription.

14 THE CHAIRMAN: I can certainly remember  
15 going into a pharmacy with a prescription and having the  
16 pharmacist take the prescription and open the door of a  
17 cabinet and take out a bottle and put a label on it and  
18 hand it to me, and it took about a minute-and-a-half.

19 MR. TURNBULL: Correct.

20 THE CHAIRMAN: Surely that is a shorter  
21 period of time - the responsibility is the same, but  
22 surely that is a shorter period of time?

23 MR. TURNBULL: That is correct. I think  
24 we are talking about averages though.

25 THE CHAIRMAN: Yes, but what I am getting at,  
26 if the proportion of prescriptions that are filled in that  
27 way are increasing, the average time would tend to decrease?

28 MR. TURNBULL: I do not believe that the  
29 average time of 7 to 8 minutes is a misrepresentation in  
30 any way because it only takes ---





1 THE CHAIRMAN: I am not suggesting it is a  
2 misrepresentation. I am just wondering if in 1960 it is  
3 as accurate as it was in 1955.

4 MR. TURNBULL: I do not believe too far off.  
5 The only difficulty is time and motion studies as we all  
6 know are very expensive operations, and I think any prac-  
7 tising pharmacist would tell you it only takes one derma-  
8 tologist's prescription for a variety of ingredients to  
9 be placed into a half-ounce ointment, and he is going to  
10 use up the best part of an hour just working on it.

11 THE CHAIRMAN: When he is compounding it he  
12 would in fact take quite a while?

13 MR. COOK: I wonder if Dr. Matthews could  
14 comment on that, sir?

15 THE CHAIRMAN: Yes.

16 DR. MATTHEWS: I would like to comment in  
17 relation to the particular question on the fact that in  
18 your opinion the amount of time may decrease as a result  
19 of the fact that more prescriptions are pre-packaged  
20 medications. I think there are many compensating factors,  
21 but I will only mention one. In the past period of ten  
22 or fifteen years, the amount of prescriptions, the number  
23 of prescriptions proportionately requiring regulation  
24 with regard to both narcotic and restricted drug control  
25 have increased to the point where not only is the pharma-  
26 cist required to spend a great deal more time in comple-  
27 ting forms necessary, and those under the most recent  
28 regulations are perfect examples, but the amount of time  
29 he spends on the telephone with the physician has  
30 increased beyond any known previous amount, to the point



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1 where I am quite sure if you were to recalculate this now,  
2 taking that into consideration as well, you would find it  
3 a very large compensating factor.

4 MR. TURNBULL: May I ask, Mr. Chairman,  
5 that the table as it appears on page 62 be taken as read,  
6 and written into the record? I will refer briefly to one  
7 or two parts of the table.

42,545 Prescriptions from 192 Pharmacies								
Price Range	% of Total Prescriptions	Cumulative Per Cent	Gross Margin %	Gross Margin \$	Average Cost of Ingredients	Average Price	Average Break-even Cost	Price by Pr'f'l. Fee Method
\$0.01 - \$ 0.50	0.7%		59.4%	\$0.27	\$0.19	\$0.46	\$1.10 <sup>a</sup>	\$2.19
0.51 - 1.00	10.4%	11.1%	50.5%	0.52	0.37	0.99	1.20 <sup>a</sup>	2.37
1.01 - 1.50	17.9%	29.0%	59.5%	0.90	0.45	1.35	1.36 <sup>a</sup>	2.45
1.51 - 2.00	17.3%	46.3%	55.6%	1.01	0.61	1.82	1.72 <sup>a</sup>	2.61
2.01 - 2.50	12.2%	58.5%	52.0%	1.22	1.10	2.32	2.01	3.10
2.51 - 3.00	10.3%	68.3%	50.2%	1.41	1.40	2.81	2.31	3.41
3.01 - 3.50	6.9%	75.7%	40.9%	1.64	1.72	3.36	2.63	3.72
3.51 - 4.00	6.0%	81.7%	46.9%	1.79	2.03	3.62	2.94	4.03
4.01 - 4.50	3.8%	85.5%	44.9%	1.95	2.30	4.33	3.29	4.36
4.51 - 5.00	3.1%	88.6%	44.5%	2.15	2.67	4.92	3.58	4.67
5.01 - 5.50	2.0%	90.6%	43.4%	2.32	3.04	5.36	3.95	5.04
5.51 - 6.00	2.7%	93.3%	42.9%	2.50	3.33	5.63	4.24	5.33
6.01 - 6.50	1.4%	94.7%	43.6%	2.75	3.57	6.32	4.40	5.57
6.51 - 7.00	0.8%	95.5%	42.7%	2.91	3.99	6.00	4.80	5.89
7.01 - 7.50	1.0%	96.5%	42.1%	3.00	4.22	7.30	5.13	6.22
7.51 - 8.00	0.9%	97.4%	43.5%	3.39	4.41	7.90	5.32	6.41
8.01 - 8.50	0.3%	97.7%	41.4%	3.46	4.69	8.35	5.90	6.99
8.51 - 9.00	0.3%	98.0%	41.0%	3.72	5.17	8.69	6.06	7.17
9.01 - 9.50	0.5%	98.5%	40.4%	3.79	5.56	9.37	6.49	7.50
9.51 - 10.00	0.4%	98.9%	42.2%	4.11	5.60	9.71	6.51	7.60
10.01 and UP	1.1%	100.0%	40.0%	5.55	6.30	13.65	9.21	10.30

<sup>a</sup> Prescriptions in these price ranges dispensed below average breakeven cost.

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30



1 THE CHAIRMAN: One point that has occurred  
2 to me, you indicate with a small letter "a" on the first  
3 four items in the second last column - that is the  
4 column which is headed "Average Breakeven Cost" - and  
5 then the note at the bottom where there is a small "a"  
6 and "Prescriptions in these price ranges dispensed below  
7 average breakeven cost". Is that right about the fourth  
8 one?

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DL, MR/hm

1 MR. TURNBULL: Not according to the figures  
2 as presented but the prices, the average price quoted  
3 there \$1.82 pertains to the overall average within that  
4 category rather than pertaining to the medium figure of  
5 the whole set of prescriptions that fall within that  
6 \$1.51 to \$2.00 category.

7 THE CHAIRMAN: The average is the same  
8 thing. Does that seem to indicate that the statement  
9 where these items are labelled with a small "a" is correct  
10 as to the three but seems to be incorrect on the fourth?

11 MR. TURNBULL: There should be a break-off  
12 there related to the very small number within that group  
13 that come above the \$1.72 figure.

14 THE CHAIRMAN: You wanted to make some  
15 comment on the table did you?

16 MR. TURNBULL: That was the one comment  
17 I was going to make. I was going to draw your attention  
18 to it.

19 The last column of the table refers to a  
20 cost-plus-professional fee concept of the pricing of  
21 pharmaceutical services which was undergoing serious  
22 study at that time and which merits considerable worth-  
23 while attention. This concept or variations of it are  
24 utilized by some pharmacists in locations across Canada.  
25 It has not, at least as yet, received any measure of  
26 acceptance throughout the profession, possibly because,  
27 amongst other reasons: (a) present pricing methods have  
28 been habitually practised for many decades; (b) hesitancy  
29 to adopt a system which is not based on a basic percentage  
30 gross; (c) reluctance to increase prices in lower brackets;



1 (d) inability to stock high cost items and store them while  
2 awaiting proportionately lower gross return.

3 MR. FRAWLEY: Mr. Chairman, I certainly  
4 would like this table explained to me. I still do not  
5 understand some of it. I could wait until time for my  
6 questioning but it seems to me it would be more useful now,  
7 just as a matter of clarification, if Mr. Turnbull would  
8 pick any one at all, pick one at random -- \$2.50 to \$3.00  
9 and if he wouldn't mind going across the page and just  
10 comment on each column. If he would do that on the one,  
11 I think we would understand what it means.

12 MR. TURNBULL: If I may, the figures in  
13 the \$1.01 to \$1.50 look nice to us.

14 MR. FRAWLEY: All right, then fine.

15 MR. TURNBULL: We find there is a percentage  
16 of total prescriptions within that category of 17.9% and  
17 up to the final figure of \$1.50. The cumulative percentage  
18 total would be 29%.

19 The prescription price for this range had  
20 a gross margin per cent of 59.5%. The gross margin in  
21 dollars is .90, ninety cents.

22 THE CHAIRMAN: Does this include a  
23 professional fee, in this gross margin?

24 MR. TURNBULL: The gross margin, yes.

25 THE CHAIRMAN: That includes a professional  
26 fee if the pharmacist happened to charge one?

27 MR. TURNBULL: No, this is the gross margin  
28 of the selling price less the ingredient price.

29 THE CHAIRMAN: That is what the purchaser  
30 actually paid. It may or may not have included a professional





1 fee?

2 MR. TURNBULL: The "purchaser"? The  
3 retail pharmacist you mean?

4 THE CHAIRMAN: Oh this is ---

5 MR. TURNBULL: I think we are talking about  
6 two different things.

7 THE CHAIRMAN: The gross margin -- I am  
8 trying to get at whether the gross margin, that is the  
9 difference between what the pharmacist paid and what he  
10 got for it?

11 MR. TURNBULL: That is correct.

12 THE CHAIRMAN: Doesn't what he gets for  
13 it include a professional fee? Some cases it did and  
14 some cases it didn't, is that it?

15 MR. TURNBULL: No. This is the difference  
16 between the actual cost of ingredients and the selling  
17 price.

18 THE CHAIRMAN: Of the drug?

19 MR. TURNBULL: Of the prescription.

20 THE CHAIRMAN: There may or may not have  
21 been a professional fee added?

22 MR. TURNBULL: This ninety cents presumably  
23 includes the professional fee, that is in markup of  
24 profit and that type of thing. This is just relating to  
25 the cost of the tangible ingredients within a prescription  
26 survey.

27 MR. COOK: There was a professional fee  
28 included?

29 MR. TURNBULL: Yes, it is in here.

30 MR. FRAWLEY: You received \$1.35 on the



1 average for these prescriptions which began at \$1.01 and  
2 went to \$1.50?

3 MR. TURNBULL: The average price was \$1.35  
4 -- the average cost of ingredients at 45¢ and the average  
5 gross margin was 90¢ in here. Applying the figures they  
6 pertain to the average break-even cost. The break-even  
7 cost in this range would be \$1.36.

8 MR. FRAWLEY: Which means that all  
9 prescriptions sold between \$1.01 and \$1.50 he lost money  
10 on them?

11 MR. TURNBULL: That is correct Mr. Frawley,  
12 from the survey figures as tabulated.

13 MR. FRAWLEY: The high priced drugs are  
14 subsidizing those, of course. That "a" notation ends.  
15 The notation "a" does not apply once you get into the  
16 prescriptions which run from \$2.01 to \$2.50?

17 MR. TURNBULL: That is right.

18 MR. FRAWLEY: Those prescriptions are all  
19 carrying themselves at least?

20 MR. TURNBULL: Yes sir. Actually, we are  
21 presenting this table and the conclusions as information.  
22 I do not believe that we are commenting further on the  
23 chart as presented here, Mr. Chairman, as to the current  
24 application of this.

25 THE CHAIRMAN: Another point that occurred  
26 to me, under the heading "gross margin" in percentages,  
27 dealing with this third line, \$1.01 to \$1.50, the gross  
28 margin of 59.5%. That is on the sales is it at \$1.01 to  
29 \$1.50 or is that a cumulative gross margin?

30 MR. TURNBULL: No, with respect to the final



1 pricing figure of prescriptions within a \$1.01 to \$1.50  
2 range.

3 THE CHAIRMAN: Would that be 59.5%?

4 MR. TURNBULL: A gross margin is applied  
5 there.

6 THE CHAIRMAN: That is what puzzles me  
7 because you show gross margin in terms of money as 90¢,  
8 cost of the ingredient as 45¢, average price then \$1.35.  
9 That seems to mean of the \$1.35, 90¢ is gross margin.  
10 It wouldn't be 59.5 but 66.7%. I am just wondering where  
11 the difference comes in. There may be something wrong in  
12 my arithmetic or else I am not understanding it properly.  
13 Priced as a markup on cost of ingredient, the markup would  
14 be 200%.

15 MR. TURNBULL: In terms of margin, not in  
16 markup.

17 THE CHAIRMAN: In terms of margin it would  
18 be 66.66% instead of 59.5%, as far as the way I would  
19 compute it on the basis the ingredients are 45¢, selling  
20 price \$1.35, gross margin then is 90¢ out of \$1.35 which  
21 is two-thirds of that.

22 MR. TURNBULL: One thing I would have to  
23 do sir is to discuss this with the gentleman who prepared  
24 the survey in that this 59.5% figure may result from an  
25 over preponderance of prescriptions in one area or another  
26 of this -- in an upper area or lower area of this \$1.01-  
27 \$1.50 category and arising from that the figures of 90  
28 and 45 might not specifically relate to the 59.5% but  
29 would relate to all the prescriptions that were in this  
30 survey category.



1 MR. FRAWLEY: Mr. Chairman, as I understand  
2 the survey was done by Professor Fuller who used the  
3 formula that was taken from the article in J.A.M.A.

4 MR. TURNBULL: In establishing break-even  
5 cost?

6 MR. FRAWLEY: Yes.

7 MR. TURNBULL: Yes, they are stated.

8 MR. FRAWLEY: Do you know the date of  
9 that survey that was reported in the American Journal?

10 MR. TURNBULL: I have attempted to determine  
11 it and frankly, Mr. Frawley, I have not got the reference  
12 with me. I am sorry. I just realized yesterday that we  
13 had not documented this and I have not been able to pick  
14 it up.

15 MR. FRAWLEY: You have not a reprint of  
16 the article?

17 MR. TURNBULL: I have not with me, no.

18 THE CHAIRMAN: Just that one that seems  
19 to be out of line. The others seem to be very close.

20 MR. TURNBULL: In my calculation I would  
21 make it sixty-six and two-thirds too. If I may discuss  
22 this with Professor Fuller and attempt to bring back an  
23 answer to you ---?

2 24 THE CHAIRMAN: I was just puzzled as to  
25 how this was arrived at. If it is on a different basis  
26 than appears to me at first sight, all right. I would  
27 just like to know what it is. The other lines seem to  
28 agree pretty well with the method I was using for com-  
29 putation of that.

30 MR. WHITELEY: Do you know if the percentages



1 have been cumulated on a dollar basis as well as on the  
2 number of prescriptions?

3 MR. TURNBULL: I will check that at the  
4 same time.

5 MR. FRAWLEY: The bottom one, \$10.00 and  
6 up, 40% is correct there, according to my poor arithmetic.

7 MR. COOK: I have two spots here that seem  
8 to be correct.

9 THE CHAIRMAN: Except this one item. That  
10 is the trouble.

11 MR. TURNBULL: Possibly we will have to  
12 check back to the original as well for typographical errors.  
13 A little bit difficult running these things when there is  
14 a multitude of figures. I do not question them at the  
15 moment.

16 THE CHAIRMAN: Would you proceed then,  
17 Mr. Turnbull?

18 MR. TURNBULL:

19 Over-the-Counter Sales:

20 The pharmacist is not qualified to diagnose  
21 illness. Sometimes the patient's symptoms make it obvious  
22 to him that the advice of a medical practitioner should  
23 be sought. However, the pharmacist is often consulted by  
24 the patient concerning the relative merits of a group of  
25 products for the treatment of self-diagnosed minor ailments.  
26 In such instances, the pharmacist is professionally com-  
27 pelled to suggest the product which will best alleviate the  
28 ailment. If the formula of the preparation appears on the  
29 label, the pharmacist is enabled to evaluate its merits,  
30 or the separate functions of its ingredients, intelligently.





1 The public has come to expect an unbiased recommendation  
2 of specific products from the pharmacist.

3               Pharmacists have been repeatedly assured  
4 that no medicine is given a patent number if it is at all  
5 unsafe for use in normal amounts.

6               The patent number reference, of course,  
7 would be the Patent or Proprietary Medicines Act.

8               It may be worthless for the treatment of  
9 certain conditions, but it is harmless. If it is worthless,  
10 is it not, then, harmful since it does not produce the  
11 required effect, or since it may tend to delay competent  
12 treatment? Normal amounts are not harmful, but what about  
13 abnormal dosages?

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1 To whom may the public turn for advice on  
2 the effectiveness and use of secret-formula medications  
3 which are registered under the Patent or Proprietary  
4 Medicine Act? Unfortunately neither physicians nor  
5 pharmacists who could evaluate these medicines are aware  
6 of their contents. Mass promotional media constantly  
7 exhort the public to use certain pills for certain ailments.  
8 The pharmacist supplies these upon demand, although he  
9 is unable to form a professional judgment of the product,  
10 due to his ignorance of its composition. Such preparations  
11 are, of course, available in a variety of non-pharmacy  
12 outlets.

13 The Association continues to urge that the  
14 secrecy clauses of the P.P.M. Act be eliminated and, as  
15 originally recommended in 1955, that "all labels bear a  
16 full statement of the quantity and names of any scheduled  
17 drug contained, along with the names of all active  
18 medicinal ingredients, each by its common name". This  
19 will help greatly in cases of overdoses and poisonings,  
20 and will enable pharmacists to professionally judge  
21 their effectiveness, toxicity and dosage schedules.

22 There are pharmaceutical specialty products  
23 legally sold without a prescription by the pharmacist which  
24 have gained a high degree of acceptance by the public,  
25 even though they are not advertised. The public has been  
26 made aware of these medications by the physician and the  
27 pharmacist because the disclosure of contents has made it  
28 possible for them to assess the quality of the ingredients.

29 Figures taken from the 1961 Canadian  
30 Consumer Survey, published by the Canadian Daily Newspaper



1 Publishers Association, as they apply to these 'O-T-C  
2 pharmaceuticals' that is; over the counter, indicate the  
3 consumer preference market as:

4 At least 21% - Cough syrup market

5 At least 25% - Nose drops market

6 At least 26% - Cold tablet market

7 At least 40% - Vitamin market

8 At least 56% - Headache remedy market.

9 THE CHAIRMAN: Perhaps you might explain  
10 what the percentages mean?

11 MR. TURNBULL: Referring to consumer  
12 preferences as divulged by this survey on what we refer to  
13 as buying the ethical pharmaceutical preparations as  
14 opposed to consumer preference in the patent or proprietary  
15 medicine preparation field.

16 THE CHAIRMAN: For instance in the cough  
17 syrup market 21% of the consumers buy O-T-C pharmaceuticals  
18 and 79 get prescription?

19 MR. TURNBULL: 79%, apparently, rely upon  
20 the advertising of the patent and proprietary medicine  
21 preparations. This is a consumer survey of a daily  
22 newspaper service publication and refers only to consumer  
23 preference purchases.

24 THE CHAIRMAN: What is the difference  
25 between O-T-C pharmaceuticals they can buy and one that  
26 is advertised and the advertising persuades people to buy  
27 it?

28 MR. TURNBULL: Basically there are several  
29 differences, but at the level of commerce the O-T-C  
30 pharmaceutical is offered for sale under the terms of the



1 Food and Drugs Act and does not have a patent and proprietary  
2 medicine registration, and therefore is offered for  
3 sale with all ingredients labelled on it and it is sold  
4 only in retail pharmacies.

5 THE CHAIRMAN: Is it advertised?

6 MR. TURNBULL: No, there is no consumer  
7 advertising of it..

8 THE CHAIRMAN: Those are O-T-C pharmaceuticals  
9 unadvertised.

10 MR. TURNBULL: Which have become known to  
11 the individual through other sources.

12 THE CHAIRMAN: A think like headache remedy  
13 market means half of the people buy that type rather than  
14 those advertised?

15 MR. TURNBULL: That was the indication of  
16 this particular survey.

17 THE CHAIRMAN: I wasn't sure exactly what  
18 was meant by the percentages. It is the percentage of  
19 those who buy O-T-C pharmaceuticals unadvertised as  
20 compared to those who buy advertised proprietary medicine?

21 MR. TURNBULL: Right.

22 The claim by an Ottawa physician who  
23 appeared before this Commission, ".....but some so-called  
24 ethical pharmaceutical companies will not allow a patient  
25 to buy over the counter .....", is only partially correct.  
26 There have been instances where a firm has expressed its  
27 wish that one or more of its products be withheld from  
28 other than prescription sale because (1) the company  
29 deemed it potentially dangerous or subject to misuse or  
30 abuse; (2) physicians often are reluctant to prescribe



1 products which have become 'counter items'; or (3) the  
2 company has no desire to gain a reputation for being  
3 anything but a producer of prescription drugs. Such  
4 policies are usually respected but there is plenty of  
5 evidence to show that the practising pharmacist follows  
6 his own dictates in such matters and tolerates no com-  
7 pulsion.

8 THE CHAIRMAN: Would the practising pharma-  
9 cist be very much influenced by the third reason?

10 MR. TURNBULL: Some might and some might  
11 not be, sir.

12 THE CHAIRMAN: I would rather think that  
13 it was none of their affair, if the company actually  
14 produced drugs, non-prescription drugs, the pharmacist  
15 might think that the manufacturer wasn't entitled to any  
16 special protection on things that weren't prescriptions,  
17 if, in fact, they did make non-prescription drugs why  
18 should they not be so known?

19 MR. TURNBULL: The differential, of course,  
20 here is legal terminology of prescription drugs as opposed  
21 to non-prescription drugs. There are only a limited number  
22 of drugs limited to prescription only sale, while there  
23 are drugs outside of that field which for these reasons  
24 the manufacturer may wish to maintain his approach to the  
25 medical profession and to the pharmaceutical profession as  
26 being a producer of fine pharmaceuticals for use by the  
27 medical profession to meet their specific diagnosis and  
28 does not wish to gain any other reputation for selling to  
29 meet the consumer, the general consumer demands. That,  
30 of course, is the individual prerogative of the individual





1 manufacturer. As I say items number 2 and 3 might not  
2 necessarily be bought by the individual practitioner.

3 THE CHAIRMAN: It struck me if the company  
4 went into the production of non-prescription drugs there  
5 is no reason why other people should help them hide the  
6 fact.

7 MR. TURNBULL: You mean if they are pro-  
8 ducing marketable drugs used for other than prescription  
9 use -- I don't think there would be any disagreement on  
10 that.

11 Pharmacists often impose sales restrictions  
12 on items because of his knowledge of their potential.  
13 Also, statutory associations have been known to make  
14 recommendations in the absence of strict legislation --  
15 e.g., that sales of codeine-containing preparations be  
16 personally supervised by the pharmacist; that certain  
17 sedatives and tranquilizers (before present legislation)  
18 be personally supervised; or other examples -- rubbing  
19 compound; hypodermic injection equipment, etc.

20 Conversely, there are 'counter items' which  
21 are sold on demand in original packages and with original  
22 labels, to meet a self-diagnosis or other diagnosis, and  
23 for use, presumably, in accordance with the will of the  
24 purchaser. These same items, when ordered by a physician  
25 for specific usage, become part of an individual pres-  
26 cription service, subject to particular precautions in  
27 handling, recording and labelling, and with the confidence  
28 of the physician being respected.

29 Costs to the Retail Pharmacist:

30 Difference in actual cost price is but only



1 one of many differences which contribute to the cost of  
2 rendering pharmaceutical services to the private,  
3 ambulatory patient. Certain of these are enumerated below:

4 1. The retailer, unlike hospitals and institu-  
5 tions and government bodies, is in no  
6 bargaining position in his purchase of drugs  
7 and pharmaceuticals. He pays the price set  
8 by the supplier, with the only variation  
9 being as a result of volume.

10 2. Unlike trade goods, maintaining a proper  
11 stock of pharmaceuticals is expensive. The  
12 vendor of trade goods may eliminate slow-  
13 moving or obsolete items by conducting a  
14 sale or otherwise disposing of them. In  
15 pharmaceuticals, an obsolete item sometimes  
16 may be returned to the manufacturer, but  
17 often it can only be destroyed at the  
18 pharmacist's expense.

19 THE CHAIRMAN: There is a point there,  
20 Mr. Turnbull, Cyanamid's brief rather indicated so far as  
21 they were concerned they took them back.

22 MR. TURNBULL: We acknowledge that, sir.

23 THE CHAIRMAN: Is that an exceptional sort  
24 of situation or do manufacturers generally take back goods  
25 which haven't been sold or which have become out-dated  
26 for one reason or the other and can't be disposed of?

27 MR. TURNBULL: Manufacturers generally  
28 will accept back for credit either in full or partial  
29 credit on the basis of replacement with other drugs, in  
30 most instances of unbroken packages of their drugs. They,



1 of course, will not touch broken packages of drugs and  
2 will not, cannot assume any responsibility concerning them.

3 THE CHAIRMAN: They don't accept any  
4 responsibility of unbroken?

5 MR. TURNBULL: They can't.

6 THE CHAIRMAN: They can't -- they don't.  
7 There is nothing to prevent a manufacturer taking it back  
8 if he recognizes it is his own goods and destroys it,  
9 which he says they normally do.

10 MR. TURNBULL: That is what they say.

11 THE CHAIRMAN: If they could identify it  
12 there would be no insuperable obstacle. They don't take  
13 back broken packages.

14 MR. TURNBULL: No, but there are certain  
15 exceptions to that, I understand.

16 THE CHAIRMAN: The general position is they  
17 don't?

18 MR. TURNBULL: The general position is they  
19 don't.

20 THE CHAIRMAN: But they do take back un-  
21 broken packages as a rule?

22 MR. TURNBULL: As a rule, yes.

23 THE CHAIRMAN: So that in most cases they  
24 can be returned. I am going to see what the full effect  
25 of this paragraph is. You say an obsolete item sometimes  
26 may be returned to the manufacturer?

27 MR. TURNBULL: You have the difficulty of  
28 "obsolete". Sometimes there are different policies of  
29 manufacturers concerning obsolete items. In other words --  
30 what example can I use? The goods might be replaced by a



1 manufacturer provided that, say, the dating is just passed  
2 or is just coming up to being the expiry date, but  
3 obsolescence in the terms of long-time obsolescence, he  
4 will not acknowledge any responsibility and, I presume,  
5 we must assume that is correct. If a man has permitted  
6 himself to retain one or two pieces that have been obsolete  
7 for some time he must accept that responsibility as well.  
8 That is the viewpoint expressed by some manufacturers in  
9 this regard, badly outdated merchandise.

10 THE CHAIRMAN: It rather indicates the  
11 pharmacist has not been checking his dates?

12 MR. TURNBULL: It could happen.

13 THE CHAIRMAN: Oh, I know it can happen.  
14 When you say sometimes may be returned that rather suggests  
15 it isn't the majority of cases, if anything it is a little  
16 unusual. Would that be a correct statement of that?

17 MR. TURNBULL: All right.

18 THE CHAIRMAN: It is somewhat unusual to  
19 be able to return goods or in the majority or great  
20 majority ....

21 MR. TURNBULL: Could we knock out the word  
22 "sometimes" so it reads "an obsolete item may be returned  
23 to the manufacturer, but sometimes it can only be destroyed  
24 at the pharmacist's expense". I think it would read  
25 better that way, yes.

26 MR. WHITELEY: Have you any figures as to  
27 the cost of that aspect in the retail pharmacy business?

28 MR. TURNBULL: We have no figures on that,  
29 Mr. Whiteley, no. I believe that the Cyanamid's brief  
30 had certain figures and the C.P.A. brief had certain figures



1 relating to the manufacturers' angle.

2 MR. WHITELEY: The manufacturers gave us  
3 some.

4 MR. TURNBULL: As far as retail pharmacy,  
5 no, I am sorry we don't.

6 3. Pharmaceuticals are purchased in units of  
7 50, 100, 500 or 1,000 or multiples thereof,  
8 and, of course, some are packaged in units  
9 which are believed to constitute useful  
10 therapeutic quantities. Prescriptions are  
11 written to suit the needs of the individual  
12 patient and various odd lots are prescribed,  
13 thus leaving a broken number of a particular  
14 item which may, or may not fit the next  
15 prescription, if any, for this item.

16 4. A pharmacist must maintain a stock of drugs  
17 in anticipation of prescriptions. Broken-  
18 package quantities must be destroyed at  
19 the end of their shelf life.

20 5. Prescription drugs are not trade goods and  
21 cannot be sold or merchandised by the  
22 pharmacist, but may only be employed in the  
23 filling or compounding of prescriptions.  
24 Maintenance of adequate stock incurs  
25 considerably higher costs of operation.

26

27

28

29

30





/c dpw

1 6. Provincial laws require a licensed  
2 pharmacist to be in charge of a retail  
3 pharmacy during the hours it is open.  
4 The pharmacist is a person with four years'  
5 university training, and his remuneration  
6 is higher than that paid to other personnel  
7 employed in the pharmacy.

8 7. Most retail pharmacies remain open for  
9 twelve or more hours per day for six or  
10 seven days each week. Proprietors, accor-  
11 ding to a U.S.A. survey, spend 59 to 60  
12 hours each week in their retail pharmacies.

13 8. The pharmacist assumes a serious respon-  
14 sibility relative to prescriptions and such  
15 involve many activities not required in  
16 straight commercial transactions.

17 9. There is considerable extra time and  
18 effort involved in the handling and recor-  
19 ding of certain classes of prescription  
20 drugs such as narcotics and 'controlled  
21 drugs'. Too, these involve considerable  
22 amounts of time spent in explaining legis-  
23 lation to the public and in telephone discus-  
24 sions with physicians.

25 Non-Dispensing Professional Activities of the Retail Phar-  
26 macist:

27 In his day-to-day activities, the pharmacist  
28 is called upon to perform many tasks which are, in essence,  
29 removed completely from his actual dispensing of prescribed  
30 drugs and medicines. These could be said to fall within



1 the category of services as an educator, communicator and  
2 interpreter with regard to community health problems with  
3 no specific remuneration being realized therefrom.

4 1. The pharmacist as a health supplies  
5 consultant:

6 The retail pharmacist is unique in that he,  
7 as a business man in his community must, by  
8 law, have an academic degree. His intensive,  
9 professional university training in various  
10 phases of health is a valuable asset which  
11 he utilizes to perform a function as a  
12 health consultant to the community in which  
13 he practises.

14 (a) Patient advice - Although not in a posi-  
15 tion to diagnose or prescribe, the pharma-  
16 cist often learns early of health problems  
17 and situations and is well equipped to  
18 advise the patient pertaining to the parti-  
19 cular way in which medicine should be used,  
20 or recommend that self-treatment be discon-  
21 tinued and medical advice sought.

22 (b) Drug advertising - Mass communication  
23 by means of radio and television often out-  
24 lines easy ways for planning one's own  
25 health needs. These are not a proper means  
26 of prescribing for the real or imagined ills  
27 of the individual and the pharmacist can do  
28 much to educate customers towards proper  
29 thinking about self-medication.

30 (c) Non-prescription drugs - Through pseudo-



1 medical articles in the popular press and  
2 magazines, fads are often begun which lead  
3 to the consumption of preparations which  
4 might well mask or promote serious condi-  
5 tions. The pharmacist, by training, is able  
6 to evaluate and advise relative to such utili-  
7 zation.

8 (d) Emergency procedures - Most pharmacists  
9 are trained to assist with the rendering of  
10 emergency or routine first aid procedures  
11 when called upon to do so.

12 (e) Prescription accessories - General  
13 advice on the use and care of therapeutic  
14 appliances as well as diagnostic aids such  
15 as thermometers, in addition to invalid  
16 rings, surgical supports, etc., is demanded  
17 of, and supplied by the community pharmacist.

18 (f) Sanitation and hygiene - A pharmacist's  
19 training equips him to advise relative to  
20 the dangerous chemicals used to combat  
21 insects and rodents, as well as problems  
22 concerning sanitation, personal hygiene and  
23 disinfection.

24 (g) Public health measures - Continuing  
25 education provides the pharmacist with  
26 scientific information on the availability  
27 and efficacy of newer public health measures,  
28 thus enabling him to support and encourage  
29 participation in immunization procedures  
30 and similar projects.



1 (h) Vaccine storage - The vaccine antitoxins  
2 and toxoids distributed free to the medical  
3 profession are, in many parts of Canada,  
4 stored in pharmacies which act as depots  
5 pending required delivery.

6 (i) Educational campaigns - Projects of  
7 health agencies are advanced through the  
8 voluntary co-operation of pharmacists who  
9 publicize programs such as Diabetes Detec-  
10 tion Week, National Health Week, Immuniza-  
11 tion Week, etc.

12 (j) Accidental poisonings - His knowledge  
13 of medicinal agents has made the pharmacist  
14 acutely aware of the problem of accidental  
15 poisoning and/or overdoses as encountered  
16 in the home. This has prompted active  
17 educational campaigns, including the distri-  
18 bution of several hundred thousand C.Ph.A.  
19 Antidote - Counterdose Charts which point  
20 up toxic potential.

21 (k) Drug warehousing - Many items stocked in  
22 the retail pharmacy have an extremely limited  
23 demand. Most good business men would not  
24 carry such items due to low mark-up or low  
25 turnover. These the pharmacist must carry  
26 because he is the only source of supply in  
27 the community for items which may be required  
28 in an emergency.

29 (l) Poisons - The law charges the pharmacist  
30 with legal responsibilities concerning the



1 custody and sale of potent poisons. The  
2 sale of such products, today, is negligible  
3 and results in little, if any, profit due  
4 to the low turnover coupled with the  
5 required record-keeping.

6 (m) Emergency Service - Pharmacy practice  
7 is not limited to normal business hours but  
8 is available to meet emergency needs of the  
9 community at all hours.

10 2. The pharmacist as a source of informa-  
11 tion to the physician:

12 A recent Health Information Foundation sur-  
13 vey in the United States explained that the  
14 pharmacist is the physician's most acces-  
15 sible source of information. Frequent  
16 enquiries may relate to product availability,  
17 dosage forms, strengths, alternate products  
18 or, possibly, merely the correct spelling of  
19 the drug so that it may be accurately desig-  
20 nated. The pharmacist presents an unbiased  
21 source of information relative to the pro-  
22 ducts of all manufacturers.

23 A study published in the "American Druggist"  
24 of April 21, 1958, shows the reasons for  
25 pharmacists receiving enquiries concerning  
26 products from physicians -

27	Names of Products	82.2%
28	Dosage	71.8%
29	Composition	69.3%
30	Availability	68.2%





Prices 65.3%

Form and packaging 63.9%

Manufacturer's name 57.4%

Refill status 18.8%

Cautions and precau-

tions 18.7%

It will be realized that this is on the basis of the complete survey, and that many of these factors would be requested in any one inquiry.

THE CHAIRMAN: The inquiry would relate to a number of these things?

MR. TURNBULL: Yes.

THE CHAIRMAN: Otherwise you would get several hundred percent?

MR. TURNBULL: Yes.

Physicians often depend on the pharmacist's prescription records for information and will call him when a review of medication and dosage prescribed on a previous patient's visit is required.

The pharmacist must often contact the physician concerning prescriptions as written, or concerning the refilling of previously written prescriptions. This is an area of professional judgment exercised by the pharmacist and the mere decision relative to further action with regard to a prescription is, in itself, an area of professional activity.

To perform proficiently as a source of



1 information requires an appreciable amount  
2 of time and effort on the part of the phar-  
3 macist. He must maintain information files  
4 relative to all drugs in a reasonably exten-  
5 sive library. He is assisted in this work  
6 through reference books which are generally  
7 available to the professions such as the  
8 "Compendium of Pharmaceutical Specialties"  
9 and the "Price Book of Drugstore Merchan-  
10 dise", both of which are published by the  
11 Canadian Pharmaceutical Association.

12 THE CHAIRMAN: I was going to ask you, it  
13 is purely a matter of information, I have not been in a  
14 dispensary of a drugstore of a pharmacist. Is that where  
15 the library is usually, in the dispensary?

16 MR. TURNBULL: Yes.

17 THE CHAIRMAN: You don't see it in the other  
18 part of the store?

19 MR. TURNBULL: No.

20 3. Other activities:

21 There are many tasks performed by the commu-  
22 nity pharmacist which are necessary to enable  
23 him to render professional prescription  
24 service, but which are not directly related  
25 to any specific, individual service:

26 (1) New developments -- These are referred  
27 to above. The pharmacist must be aware of  
28 all products, their indications, dosage and  
29 toxicity, as such might be required by the  
30 physicians of his community. There may be



1 approximately 5,000 products on the Canadian  
2 market, prepared in various pharmaceutical  
3 forms and strengths, to a total of some  
4 8,000 items.

5 As was mentioned earlier, the compendium  
6 lists some 7776 items.

7 (2) Purchasing -- Critical evaluation of  
8 each product, of the prescribing habits of  
9 physicians, as well as the possible O-T-C  
10 items he may be required to supply, consumes  
11 much time and complicates pharmaceutical  
12 purchasing.

13 (3) Legal records -- Federal and provincial  
14 legislation require the keeping of detailed  
15 records of all receipts, inventory and dis-  
16 bursements of an ever-increasing number of  
17 medications, and a tremendous number has  
18 been added to this within the past five weeks  
19 with the new controlled drug legislation.

20 (4) Storage -- Supervision of storage  
21 methods, as well as the dating of perishable  
22 products, is required of the pharmacist to  
23 ensure that potency is not compromised.

24 (5) Equipment maintenance -- Although, today,  
25 extemporaneous compounding may represent  
26 only a 7% to 10% portion of the prescrip-  
27 tions dispensed, dispensary equipment which  
28 is necessary for the accurate compounding  
29 of medications must be maintained to meet  
30 all needs.



1 All of the above constitute services  
2 rendered by the pharmacist which are an integral part of  
3 his overall cost of operation for which he expects no  
4 specific compensation, but which, quite naturally, are  
5 part of the cost of pharmaceutical services rendered to  
6 individual persons within a community. It should be  
7 recognized that in the pharmacist's assumption of these  
8 ethical, moral and legal responsibilities, costing of  
9 pharmaceutical services cannot be related to the mere  
10 purchasing of a commodity at a retail price. These respon-  
11 sibilities assumed by the pharmacist are self-imposed,  
12 self-regulated and self-enforced, through adherence to a  
13 code of ethics and through his own financial participation  
14 in the enforcement of provincial statutes which are  
15 written to govern the profession of Pharmacy and to pro-  
16 tect public health and welfare in his province.

17 THE CHAIRMAN: Mr. Turnbull, this might be  
18 a good spot for a break before another main heading.

19  
20 --- Short Recess  
21  
22  
23  
24  
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28  
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30



AT/hm

1 MR. TURNBULL:

2 Prescription pricing methods vary to a  
3 large degree across Canada. There are many "guides" or  
4 "schedules" outlining suggested methods or detailing  
5 agreements, such as those entered into with the Department  
6 of Veterans Affairs, the Health Departments of Saskatchewan,  
7 British Columbia and Manitoba, and in municipalities,  
8 as negotiated by provincial and/or local pharmacists'  
9 associations. Although there is no uniformity in pres-  
10 cription pricing, guides of one kind or another are  
11 generally used by pharmacists. Tariffs, schedules, and  
12 guides are similarly used by physicians, architects,  
13 lawyers, ad-men, unions, dentists, and others in practically  
14 all walks of life.

15 The variations across Canada, coupled with  
16 current public interest in drug prices, prompted the  
17 Canadian Pharmaceutical Association to undertake a com-  
18 prehensive study of the situation, beginning a few years  
19 ago. During the course of this study, it became very  
20 apparent that governments are hastily moving towards  
21 greater health care programs which could eventually include  
22 pharmaceutical services.

23 THE CHAIRMAN: I suppose some of our people  
24 who are anxious to get these things done might object to  
25 the word "hasty".

26 MR. TURNBULL: I would rather the word be  
27 left in, sir.

28 Thus, the Association's Committee on  
29 Economics viewed the necessity of a nationwide prescription  
30 pricing method as being an urgent requirement to most





1 contractual agreements, not only with governments, but  
2 also with insuring agencies and other groups which might  
3 assume obligations on behalf of participating individuals.  
4 Many of the current pricing methods involve a 60%  
5 breakdown formula based on list prices of original package  
6 quantities, plus a small professional fee of 75¢.

7 THE CHAIRMAN: Would you just explain what  
8 the 60% break-down means?

9 MR. TURNBULL: To explain that, sir, would  
10 be taking the original quantity as being a package of 100.  
11 The half quantity or 50 would be determined as 60% of the  
12 list price of the original quantity, plus the professional  
13 fee of 75¢. The same applies to the one-quarter quantity.  
14 It would be 60% of the higher quantity, 60% of the half  
15 quantity.

16 THE CHAIRMAN: 60% of the half?

17 MR. TURNBULL: Yes.

18 At the national level, a guide has now been  
19 designed to provide for equitable prices from the public  
20 standpoint, while ensuring a reasonable remuneration for  
21 professional services. Based on list price, it in-  
22 corporates the fee of 75¢, together with a 50¢ charge to  
23 compensate for the time, wastage and additional recording  
24 procedures involved in the dispensing of broken-package  
25 sizes.

26 THE CHAIRMAN: That means, does it, 75¢  
27 would apply in all cases?

28 MR. TURNBULL: Yes.

29 THE CHAIRMAN: 50¢ would only apply where  
30 you have broken-package sizes?



1 MR. TURNBULL: Yes.

2 As presented to the 1960 Annual Meeting, it  
3 reads:

4 "1. List price plus professional fee be the  
5 basis for establishing a Dominion Prescrip-  
6 tion Pricing Guide.

7 2. The professional fee of seventy-five cents  
8 to be charged on all original packages.

9 3. An additional fee of twenty-five cents to  
10 be charged on original packages of narcotics.

11 4. Fractional quantities of original containers  
12 be based on that fraction of original list  
13 plus the professional fee (75 cents) and a  
14 breakage charge of fifty cents. (i.e.  
15 price shall be based on list price of minimum  
16 original size plus \$1.25).

17 5. To permit variations due to differing pro-  
18 vincial conditions it is suggested that  
19 the fifty cents breakage fee may be increased  
20 or decreased as circumstances dictate, but  
21 that the professional fee of 75 cents be  
22 left untouched throughout.

23 THE CHAIRMAN: This paragraph 4 relating to  
24 fractional quantities, does that have any relation to this  
25 60% breakdown formula?

26 MR. TURNBULL: No. This breakdown by point  
27 is the actual schedule as brought forth, and relates to  
28 the immediately preceding sentence. Based on list price,  
29 it incorporates the fee of 75 cents, together with the  
30 50 cent charge to compensate, et cetera.



1 THE CHAIRMAN: In this list, there is no  
2 60% breakdown formula at all?

3 MR. TURNBULL: No.

4 The Pharmaceutical Economics Committee reported further  
5 to the Semi-Annual Meeting of the Executive Committee in  
6 February, 1961, and its broad recommendations relative to  
7 extemporaneously compounded prescriptions were accepted.  
8 This latter pertains to between 7% and 10% of all  
9 prescriptions and takes into account break-even costs  
10 related to overhead expenses and ingredients where the  
11 cost of such are of pertinent significance.

12 In accepting this guide at the 1960 Annual  
13 Meeting for further consideration on the part of provincial  
14 constituent organizations, Council agreed with its Committee,  
15 "THAT the National Prescription Pricing Guide, as outlined,  
16 be the one used if, as and when negotiations are entered  
17 upon for a national health plan." The news that a national  
18 pricing guide was being formulated did bring forth  
19 favourable enquiries from one federal government agency  
20 anxious to use same to negotiate pharmaceutical services  
21 on behalf of its beneficiaries who are located in all  
22 provinces and territories of Canada.

23 The Director's Statement concedes, to a  
24 point, that the Prescription Pricing Guides in use in  
25 provinces, districts and communities across Canada, are  
26 truly guides only, and that no statutory or otherwise  
27 disciplinary power is exerted by any association to obtain  
28 compliance with any one of them, either in whole or in  
29 part.

30 MR. FRAWLEY: Who publishes the National



1 Prescription Pricing Guide? I see you use capital letters.  
2 It must be a book, a publication.

3 MR. TURNBULL: It is not published, sir,  
4 at least to my knowledge. It is the result, as indicated  
5 on the previous page, arising from the discussions held  
6 at our 1960 Annual Meeting when it considered the report  
7 of our committee on pharmaceutical economics.

8 The capital letters are used because it  
9 relates particularly in our mind to a specific piece of  
10 literature of the Association.

11 MR. FRAWLEY: I don't mean it has been  
12 published that a person could go in and buy it; but it is  
13 a document, a book, a thing?

14 MR. TURNBULL: It is half a piece of paper.

15 MR. FRAWLEY: Just one piece of paper?

16 MR. TURNBULL: Yes. It is quoted on page  
17 71 as presented to the 1960 annual meeting. It reads,  
18 1, 2, 3, 4, 5.

19 THE CHAIRMAN: Does it not contain anything  
20 more than that?

21 MR. TURNBULL: It doesn't have to contain  
22 anything more than that.

23 THE CHAIRMAN: Your paragraph dealing with  
24 "extemporaneously compounded prescriptions were accepted".

25 MR. TURNBULL: The paragraph added to that,  
26 but Mr. Frawley's comment was concerning paragraph 2 I  
27 thought, Mr. Chairman, I'm sorry, where we make mention of  
28 the 1960 annual meeting. In 1961, February 1961, the  
29 balance or this additive was put to the National Prescription  
30 Pricing Guide as we knew it in 1960.



1 MR. FRAWLEY: No, I'm sorry, Mr. Turnbull,  
2 I was certainly talking about something else. I was  
3 talking about the thing that Mr. MacLeod was talking about  
4 at the Calgary sitting, this book that every dispensary  
5 has where he can just turn it open and find out what the  
6 manufacturer's list price is.

7 MR. TURNBULL: I don't believe there is  
8 any connection between the two.

9 MR. FRAWLEY: That is not the document you  
10 are talking about here anyway?

11 MR. TURNBULL: No, sir.

12 THE CHAIRMAN: This has not been finally  
13 adopted, has it? As I understood, it was accepted for  
14 further consideration on the part of the provincial  
15 constituent organizations.

16 MR. TURNBULL: Yes.

17 THE CHAIRMAN: Has it been accepted by the  
18 provincial constituent organizations?

19 MR. TURNBULL: It has never been ratified  
20 as such by the provincial constituent organizations.

21 THE CHAIRMAN: The national body believe  
22 it to be fairly satisfactory?

23 MR. TURNBULL: Yes.

24 THE CHAIRMAN: Are you waiting for reports  
25 from the constituent associations as to whether they have  
26 dealt with it?

27 MR. TURNBULL: Well, as the paragraph states  
28 "be the one used if, as and when negotiations are entered  
29 upon for a national health plan".

30 THE CHAIRMAN: That is not in operation now





1 at all?

2 MR. TURNBULL: No.

3 THE CHAIRMAN: Only in preparation for  
4 something that may be postponed for some years?

5 MR. TURNBULL: That is correct.

6 MR. FRAWLEY: In Calgary, at page 1074,  
7 Volume 10, I was having some difficulty about price lists,  
8 and Mr. MacLeod said "Perhaps I can interject here. It  
9 is explained elsewhere in the statement...." meaning the  
10 Director's statement -- "that the pricing material used  
11 in British Columbia and to some extent in the Province of  
12 Alberta, differed from that used in other parts of Canada.  
13 There is a service published in Vancouver, the Druggists'  
14 Bulletin Service, D.B.S., which found wide acceptance in  
15 British Columbia. The exact extent we could not establish,  
16 but it is used to a large extent in Alberta, so the use of  
17 this book, the price book published by the Canadian  
18 Pharmaceutical Journal, the use was much less common in  
19 Alberta, because they had the substitute system, and it  
20 is made clear in other parts of the statement." That  
21 book published by the Canadian Pharmaceutical Journal is  
22 not what you are speaking about here at all?

23 MR. TURNBULL: No, sir.

24 MR. COOK: I think I can clear up Mr.  
25 Frawley's difficulty, and I am sure Mr. Turnbull will  
26 correct me if I misstate it. He is referring to a book  
27 which I understand is nothing but a compilation of manu-  
28 facturers' list prices. Nothing more than that. It is  
29 simply a collection. No independent judgment of any kind  
30 exercised by anybody. Manufacturers have price lists.



1 This guide which is referred to, my under-  
2 standing is it contains no prices whatsoever. It is simply  
3 a method of pricing, but the actual prices -- all it  
4 consists of is set out in that brief. There are no in-  
5 dividual prices contained.

6 MR. FRAWLEY: It contains all those prices  
7 and it also indicates in addition to the list price, the  
8 price which the patient with the prescription pays; it  
9 also indicates discount off that price which the retailer  
10 pays?

11 MR. TURNBULL: I will be referring to that  
12 other book in a further part of my brief, Mr. Chairman.

13 THE CHAIRMAN: This is not the same document  
14 at all.

2 15 MR. COOK: One point I want to make: The  
16 book which Mr. Frawley is talking about is not a book  
17 which in any sense is adopted by the Association. The  
18 Association has nothing to say about the contents. It is  
19 only a collections of material which is available to  
20 anybody.

21 MR. FRAWLEY: I am obliged to my friend for  
22 that explanation.

23 MR. TURNBULL:

24 A prescription is not an item of commerce  
25 or trade, nor is it a merchandise commodity. A prescrip-  
26 tion drug is placed in the hands of a specific patient  
27 as the end result of a pharmaceutical service ordered by  
28 a medical practitioner.

29 From his association, the individual member  
30 expects guidance but nothing more --- and, indeed, will



1 tolerate nothing more. He expects guidance and suggestions  
2 in the fields of economics and administration. He knows  
3 that from no other source may he contemplate receiving in-  
4 formation which, if he were a staff member of a large  
5 organization such as a chain operation, would be forthcoming.  
6 We believe that an association is properly acting within  
7 its general role by signifying its approval of a professional  
8 fee structure system in a professional service which in-  
9 cludes a tangible product, provided that such structure is  
10 realistic and equitable to all parties.

11                   There is more than ample evidence that  
12 pharmaceutical services related to any one prescription  
13 item are available at a variety of prices in any community  
14 or province. To mention proof of such, as obtained by one  
15 set of 'researchers', we quote the headlines of the Toronto  
16 Telegram of December 12, 1959, "City Drug Prices Show 27%  
17 Spread", resulting from the purchase of nine prescriptions,  
18 the legality of some of which need not be discussed here.  
19 Then, on December 15, 1959, the Toronto Star published its  
20 'research survey' of similar results with headlines, in red,  
21 "How You Can Be Bilked When Buying Drugs". One could only  
22 observe that "you can't win!"

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1/dpw

1 THE CHAIRMAN: Adding, I suppose, the Tele-  
2 gram of yesterday's date?

3 MR. TURNBULL: I don't think there is any  
4 sense in putting it in as an exhibit sir. "Drugs - Poor  
5 Pay Most, on a survey of nine stores in the city".

6 THE CHAIRMAN: And about seven different  
7 prices I think were disclosed?

8 MR. TURNBULL: Yes, that is correct,  
9 ranging I believe from 95 cents to ---

10 THE CHAIRMAN: \$1.85?

11 MR. TURNBULL: To \$1.85, yes.

12 MR. FRAWLEY: Those are not prescriptions?  
13 That was not a prescription drug of course?

14 MR. TURNBULL: Yes, certainly. It was  
15 obtained on prescription.

16 MR. FRAWLEY: It's a vitamin preparation  
17 of Abbott's. Did this reporter go armed with 15 prescrip-  
18 tions?

19 THE CHAIRMAN: Perhaps you'd better read  
20 it. I asked myself the same question.

21 MR. FRAWLEY: He must have had 20 prescrip-  
22 tions.

23 THE CHAIRMAN: I think he said he was armed  
24 with prescriptions. Perhaps you'd better read it in case  
25 it does touch on the point.

26 MR. TURNBULL: Quoting from the Telegram,  
27 Monday October 23rd, 1961: "And it's the poor people who  
28 pay the most. Armed with prescriptions for Dical-D - a  
29 common drug prescribed for people with a calcium defici-  
30 ency - I went to nine different Metro drugstores..."



1 Do you wish the names read into this as  
2 well?

3 THE CHAIRMAN: I don't think you need to.  
4 He was operating on a prescription. At least that is  
5 what the paper said.

6 MR. TURNBULL: I think we should have a  
7 clarification of terminology. A prescription drug is  
8 any drug regardless of its legal restriction or otherwise  
9 that is prescribed for a patient and made available to  
10 that patient as part of the pharmaceutical service  
11 ordered by a physician; whether the drug, the tangible part of  
12 the prescription, was legally restricted to prescription  
13 is the only point.

14 MR. FRAWLEY: I don't want to be led off in  
15 any bypass. I don't know how important or major this is  
16 in the deliberations of this Commission. If that reporter  
17 was going about and buying on prescription, he would have  
18 to surrender that prescription every time.

19 MR. HUME: He had nine of them.

20 MR. FRAWLEY: He must have had more than  
21 nine. Did he go to nine or more than nine?

22 THE CHAIRMAN: Nine stores.

23 MR. TURNBULL: Maybe I should carry on with  
24 part of this to clarify. "Armed with prescriptions..."  
25 "...for Dical-D..." this gentleman apparently had nine  
26 prescriptions and went to those pharmacies, this nine  
27 that he divulges anyway.

28 MR. FRAWLEY: That is just fantastic. That  
29 is all. I just don't know whether he went to nine physi-  
30 cians and got nine prescriptions or did he go to one





1 physician who gave him nine prescriptions so he could  
2 participate in this contest?

3 I am sure I wouldn't ascribe that to any  
4 physician at all. I mean no such implication in what I  
5 said but I suggest you can go in over the counter and buy  
6 Dical-D capsules which are dicalcium phosphate and Viosterol  
7 - which is Vitamin D.

8 THE CHAIRMAN: It may be Mr. Frawley. This  
9 of course is not direct evidence any more than these were.  
10 This is what the newspaper has reported and what it has  
11 reported says he was armed with prescriptions. It seems  
12 to indicate he got this drug - could have been obtained  
13 without prescription - from nine different stores and  
14 about seven different prices, one of them being more than  
15 twice the lowest price.

16 MR. MACLEOD: Mr. Chairman, there was evi-  
17 dence at several hearings that certain vitamin preparations,  
18 although they are not actually required to be sold by pres-  
19 cription under law, have such therapeutic qualities that  
20 the druggist will not sell them without a prescription and  
21 I was wondering if we could ask some of the medical experts  
22 or pharmaceutical experts here if these products are such  
23 products or prescriptions in this compendium.

24 MR. TURNBULL: Dical-D is not a product  
25 which by any piece of legislation is restricted to pres-  
26 cription only to sell but when it is prescribed by a physi-  
27 cian it automatically becomes a prescription drug and if a  
28 physician prescribes an acetylsalicylic acid by chemical  
29 name or by any trade name such as aspirin or anything else,  
30 immediately he writes that on a prescription and entrusts



1 it to a pharmacy to dispense, label and place in the hands  
2 of the patient, that acetylsalicylic acid becomes a pres-  
3 cription drug.

4 MR. MACLEOD: Yes, I think that is quite  
5 clear Mr. Turnbull but the point I was raising was that  
6 certain vitamin products will be sold by a druggist -  
7 some druggists testified that certain vitamin products -  
8 they call them therapeutic vitamins or something, they  
9 said they would not sell without a prescription despite  
10 the fact that a prescription was not legally required.  
11 I was wondering if this particular product falls within  
12 the class described by those druggists?

13 MR. TURNBULL: No sir.

14 MR. MACLEOD: It doesn't, all right.

15 MR. FRAWLEY: Mr. Chairman, one more thing  
16 and then I will stop. I think it is important to know  
17 that prescriptions are not obtainable by a penny-in-the-  
18 slot basis. When I consult a physician and obtain a  
19 prescription I pay him a consulting fee which nowadays  
20 is running about \$10. Now that has to be added to the  
21 price that I pay when I go out to get the Viosterol with  
22 the calcium phosphate. Did this newspaper reporter go  
23 to ten physicians and pay a consulting fee of \$10?

24 THE CHAIRMAN: We have only heard what the  
25 papers say.

26 MR. FRAWLEY: The witness is making some-  
27 thing of it. I think we should have the whole story.

28 THE CHAIRMAN: I asked him if he was going  
29 to introduce it because I have not seen it and it has  
30 referred to varying prices just as this did.



1 MR. HUME: I think it ought to be noted  
2 that any newspaper reporter can go to a doctor friend and  
3 say he wants to make a survey. Supply me with 20 pres-  
4 criptions so I can and the doctor would write out the  
5 prescription without any charge for the fee and would be  
6 most interested in the result.

7 MR. FRAWLEY: I don't think so.

8 THE CHAIRMAN: Gentlemen, we are talking  
9 in the dark. We don't know what happened and we do not  
10 have any evidence.

11 MR. COOK: I might say Mr. Chairman, if Mr.  
12 Frawley has a quarrel it must be with the Telegram, not  
13 with this witness. He did not send out the reporter.

14 MR. TURNBULL: It might have been a good  
15 idea.

16 THE CHAIRMAN: This is another instance of  
17 varying prices, apparently.

18 MR. TURNBULL: Yes.

19 History:

20 History can serve to illuminate current  
21 problems and issues. A knowledge of past experience can  
22 sharpen judgments as to the values and propriety of present-  
23 day activities.

24 In Europe, dating back to the German Empire  
25 when Frederik II's edict separated medicine and pharmacy  
26 in 1240, there have been several carefully elaborated  
27 lists of governmentally-established prices. Possibly the  
28 first published in North America was a compounding fee  
29 schedule which was part of the "Catalogue of Materia  
30 Medica and of Pharmacy Preparations with the Uniform



1 Prices" of the Massachusetts College of Pharmacy in 1828.  
2 Many other formulations appeared over those years to  
3 establish sanity in pricing, in recognition that 'price-  
4 cutting' in prescriptions was, as quoted from American  
5 journals, "dangerous to the profession of pharmacy and  
6 even more important, to the public health and patient wel-  
7 fare". The Massachusetts College of Pharmacy I understand  
8 at that time was a retail pharmacy organization prior to  
9 it being established as an educational body.

10 The Canadian Pharmaceutical Journal,  
11 Volume 14, 1880-81, printed a "proposed tariff for medi-  
12 cines supplied by physicians to their patients as adopted  
13 at a recent meeting of the College of Physicians and  
14 Surgeons of the Province of Quebec. The tariff has been  
15 submitted to the Lieutenant Governor for his approval:

16	Mixtures and draughts up to two	
17	ounces .....	\$ 0 25
18	Mixtures and draughts up to four	
19	ounces .....	50
20	Mixtures and draughts up to eight	
21	ounces .....	1 00
22	Powders from one to six (1 to 6) ....	25
23	Do do six to twelve (6 to 12).	50
24	Pills per box of one dozen .....	50
25	Do for each additional dozen .....	25
26	Lotions, injections, etc, etc., 4 to	
27	16 ounces .....	50 to \$1
28	Liniments, embrocations, etc., 4	
29	to 8 ounces .....	50 to \$1
30	Blisters and plasters, according to	
	size .....	50 to \$1
	Ointments per ounce box .....	25 to 50



1 When costly drugs or medicines are used the charge to be  
2 augmented according to value".

3 THE CHAIRMAN: A person buying drugs today  
4 would look at those as the good old days.

5 MR. TURNBULL: I don't know if he was buying  
6 the plasters and blisters whether he would or not.

7 THE CHAIRMAN: The prices I am speaking  
8 about.

9 MR. TURNBULL: The fate of this foregoing  
10 Prescription Price Guide is not known. Nor is it possible  
11 to recount periods of Price Guide evolution in Canada or  
12 its provinces. It would appear that our proximity to the  
13 U.S.A. and our knowledge of schedules developed by a multi-  
14 tude of sources there guided Canadian pharmacists in the  
15 establishment of the present traditional manner of pricing  
16 prescriptions. Actual formulation and publication of  
17 Canadian systems undoubtedly arose through the demands for  
18 contractual agreements by governments and insuring bodies  
19 who wished to purchase pharmaceutical services for benefi-  
20 ciaries without any wide discrepancies in prices. The  
21 mere contemplation of such contracts hastened formulations,  
22 of course, and the format and principles of that used in  
23 Saskatchewan today is very similar to the original publi-  
24 shed in 1941 at the close of a lengthy period of welfare  
25 activities such as was experienced in the "depressed  
26 1930's". Relief prescriptions of that period were bought  
27 according to pricing schedules, as they are today.

28 At the close of World War II, the Department  
29 of Veterans' Affairs contracted to provide pharmaceutical  
30 services through the pharmacy of the patient's choice, in





1 accordance with generally-approved schedules in each  
2 province. The Indian Health Service Branch of the Depart-  
3 ment of National Health and Welfare provides essential  
4 drug service to indigent Indians outside of reserves  
5 through contracts with individual pharmacy practitioners  
6 and has indicated a desire to be able to establish such  
7 service on the basis of a Canada-wide Prescription Pricing  
8 Guide formulated by the C.Ph.A.

9           Returning momentarily to the U.S.A. picture,  
10 it is of interest to note that a multitude of price guides  
11 exist in addition to that of the National Association of  
12 Retail Druggists, 1908, and of the American Pharmaceutical  
13 Association, 1917. A national drugstore survey, under-  
14 taken in 1931 by the United States Department of Commerce,  
15 included a plan for the creation of a National Prescription  
16 pricing schedule. This plan was not carried out as it was  
17 found that a number of meritorious schedules already  
18 existed and thus, the report said: "It would seem that the  
19 solution of the problem is rather in co-ordinating exist-  
20 ing schedules than attempting to evolve new ones.  
21 Improved consumer reaction could be expected by a lowering  
22 of the present wide discrepancy in prescription prices  
23 and it would seem that the only way in which such a condi-  
24 tion could be brought about would be through the use of  
25 the existing schedules or an improved simplified national  
26 schedule". ("Government Activity Affecting Pharmacy",  
27 Griffenhagen, G.B., "The Pennsylvania Pharmacist", August,  
28 1961). These facts forcibly came to the attention of the  
29 C.Ph.A. Committee on Pharmaceutical Economics when it was  
30 directed to review pricing habits of Canadian pharmacists



1 and, thus, prompted its attempts toward a simplification  
2 of existing methods for use in contractual arrangements.

3 Steps and procedures required of a pharmacist in the  
4 dispensing of any prescription are numerous and include:

5 1. Identification of validity and legality  
6 of prescription - The pharmacist must assure  
7 himself that the order, either verbal or  
8 written, that he has received is, in fact,  
9 a legal prescription to be used for the  
10 particular purpose for which the physician  
11 has intended it.

12 2. Identification of physician and patient  
13 - The signature of the physician, or his  
14 voice in verbal prescriptions, must be known  
15 to the pharmacist. If the pharmacist cannot  
16 readily identify the signature or voice, he  
17 is required to take steps to verify same.  
18 He must also be reasonably certain that the  
19 prescription is being dispensed for the use  
20 of the specific person named thereon and  
21 that, in effect, the prescription is not  
22 being given, bartered or sold by the patient  
23 named, for use by another. Checking often  
24 enables the pharmacist to recognize prescrip-  
25 tion forgeries which have recently become  
26 more prominent in the field of habit-forming  
27 medications. Through his knowledge of, and  
28 personal contact with the patient, the phar-  
29 macist may be able to advise the physician  
30 that a particular patient is, or has been



/PB/hm

1 receiving potentially dangerous medications  
2 from more than one practitioner.

3 3. Deciphering the prescription - The  
4 pharmacist must ensure that he can decipher  
5 the handwriting on the prescription  
6 unmistakably. This is not always easy.

7 THE CHAIRMAN: Is that as much of a problem  
8 as some humourist would lead us to believe?

9 MR. TURNBULL: I think my colleagues in  
10 pharmacy will bear out there sometimes is some difficulty  
11 in reading physicians' writing. I have with me, sir, an  
12 article that reported an address in the American Medical  
13 Association Journal at a convention of the American  
14 Medical Association in which one physician accused the  
15 doctors in attendance of contributing greatly to the cost  
16 of drugs because of the time involved in the pharmacist  
17 attempting to decipher their writing.

18 THE CHAIRMAN: And checking back to make  
19 sure that he had deciphered it correctly. That would be  
20 part of the time. If it is a serious problem it might  
21 involve quite a bit of time.

22 MR. TURNBULL: This is not easy. It must  
23 be done with great accuracy.

24 Complexity and similarity of names may  
25 provide the pharmacist with an additional  
26 problem. For example, Preludin is an  
27 appetite depressant drug used in the manage-  
28 ment of obesity, but Proluton is an oral  
29 hormone product used in various femal  
30 reproductive disturbances. Tensilone is a



1                   nitroglycerine and diuretic formula for use  
2                   in high blood pressure, while Tensilon  
3                   is a powerful antagonist of curare which,  
4                   itself, is a very potent muscle relaxant.  
5                   These are but two examples -- many more could  
6                   be cited. The pharmacist cannot be  
7                   approximately right in his interpretation of  
8                   the medicament prescribed. He must be aware  
9                   that such similarity of names exists and,  
10                  if necessary, verify his opinion with the  
11                  prescribing physician.

12                4. Checking the dosage - Should any harm  
13                ensue, the pharmacist assumes responsibility  
14                when an overdose is inadvertently prescribed  
15                and he dispenses it as written. Here, he  
16                protects equally the physician and the  
17                patient. To recognize overdoses, the  
18                pharmacist must have intimate knowledge of  
19                the suggested maximum dosage schedules. He  
20                takes into account the age of the patient  
21                and any special intolerances known to him  
22                in assessing the safety of the dosage level.  
23                A seemingly innocent dose of a tonic with a  
24                low alcohol content may be exceedingly  
25                dangerous to the well-being of a patient  
26                who has been successfully withdrawn from  
27                alcohol addiction unbeknown to the pre-  
28                scribing physician.

29                5. Determination of quantity - The pharma-  
30                cist must next calculate, by precise



1 mathematics, the quantities he will need  
2 for each of the ingredients in the prescrip-  
3 tion. If the prescription is simply written  
4 for a prepared dosage form of the medication,  
5 he need only determine the total number of  
6 doses which will be required.

7 6. Assembling the ingredients - The  
8 pharmacist adopts a safeguarding routine  
9 when he assembles all the ingredients needed,  
10 and lines them up on his prescription desk  
11 prior to filling the prescription. Each  
12 ingredient is thus checked against the  
13 written prescription. This step may also  
14 entail the choice of the, or by the pharmacist  
15 as to the quality of the ingredients. If  
16 the prescription is written for a trade-  
17 named product or a combination of such  
18 products, the pharmacist will use exactly  
19 the brand or trade name specified. If,  
20 however, the prescription includes basic  
21 chemicals or medicinals specified by  
22 chemical or generic name, the choice of  
23 product is left to his discretion and he  
24 must dispense a chemical or medicinal agent  
25 which is believed by him to be of the highest  
26 quality. Thus, a knowledge of the source  
27 of supply and the relative care exercised  
28 by various manufacturers in their production  
29 and quality control functions is essential.  
30 The pharmacist must ensure that all the





1 ingredients are fresh and have been stored  
2 in such a manner that their medicinal  
3 properties have not been compromised. A  
4 drug of less than stated potency can be much  
5 more dangerous than no drug at all, since  
6 it will not produce the required result.

7 7. Filling the prescription - The pres-  
8 cription must be filled in the manner best  
9 calculated to yield the product desired by  
10 the physician. This involves a comprehen-  
11 sive knowledge of incompatibilities, chemical  
12 properties and flavourings. One chemical  
13 or drug in direct combination with another  
14 may react to produce something entirely  
15 different which will not give the desired  
16 result when ingested by the patient.

17 8. Choice of container - Many medicaments  
18 require special containers in order to main-  
19 tain an acceptable physical form and  
20 potency. Some must be protected from light  
21 in a brown glass bottle, while others may  
22 decompose or lose potency if left in contact  
23 with the atmosphere. Exact knowledge as to  
24 the physical and chemical nature of the  
25 ingredients in the prescription is required.

26 9. Preparation of the label - The label  
27 affixed to the container must contain, in  
28 addition to precise and exact directions for  
29 use, such information as the serial number  
30 assigned to the particular prescription



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1 which would facilitate the location of the  
2 original prescription, should it be required  
3 at some future time, the name of the patient,  
4 the name of the physician, and the date on  
5 which the prescription was dispensed. This  
6 interpretation of the physician's instruc-  
7 tions can only be performed by a pharmacist.  
8 10. Special labels - Through his knowledge  
9 of the product contained, the pharmacist  
10 must affix a label to the container bearing  
11 special instructions on the storage and  
12 handling of the prescription. These may  
13 be such things as "refrigerate but do not  
14 freeze"; "keep out of the reach of children";  
15 "keep in a cool, dark place", etc. These  
16 labels are specifically tailored to the  
17 nature of the ingredients in the prescrip-  
18 tion and are affixed with a knowledge of the  
19 particular idiosyncrasies peculiar to a  
20 drug or preparation.  
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11. Register entry - Various federal and provincial statutes make record-book entries mandatory for many prescriptions. The details of a prescription, with its serial number, are included, as are the name of the doctor, name and address of the patient, initials of the dispensing pharmacist, the physical form of the prescription, the date and quantity of the medication dispensed. Many pharmacists keep similar records for all prescriptions for convenience in location at a later date, in the event that the patient has lost or misplaced the serial number.

12. Prescription notations - The serial number assigned to the prescription is entered on the prescription itself, as is the date, the pharmacist's initials and the price and such other information as will enable a future refill to be handled in a precise manner.

13. Double checking of entire process.

14. Replacing ingredients - The replacement of the ingredients to their proper place on the shelves is, in itself, a further check on the correctness of the ingredients.

15. Income tax receipt - Since prescriptions are income tax deductible, the pharmacist is required to present the patient with a suitable legal receipt making specific



reference to the file number of the prescription, the name of the recipient, the date, and bearing the pharmacist's signature or initials.

16. Filing - All original prescriptions are filed in sequence by serial number and date so that ready future reference can be made to them. All such files must legally be maintained for a minimum of two years, although most pharmacies maintain them indefinitely.

17. Transferral of the prescription to the customer - At this point, the pharmacist is often able to mention any further verbal instructions which may be made necessary by the nature of the preparation and, at that time, draw the patient's attention to special conditions of storage, use, etc.

It is again emphasized that a prescription is a personal thing prepared in keeping with the requirements dictated by a physician's diagnosis of the patient's specific needs. In all the various steps required in the rendering of pharmaceutical services, including the record keeping, the pharmacist is charged with the responsibility of maintaining the confidence of both physician and patient.

The advent of new pharmaceutical products which necessitate complicated and costly production procedures has reduced the amount of time devoted to actual compounding of medicines by pharmacy practitioners. However, none of the foregoing steps can be eliminated in



1 dispensing a single prepared medication if the health of  
2 the individual and, consequently, of the community is to  
3 be adequately protected. In practice, pharmacy techniques  
4 have become less important, while Pharmacy's knowledge of  
5 medicinals, their uses, contraindications, dosages and  
6 toxicity have become increasingly vital. This has been  
7 brought to the attention of the Commission by non-pharma-  
8 cists during its hearings across Canada, and is under-  
9 scored also by a statement made by the President of the  
10 American Medical Association in 1959 that, "During these  
11 years of drug progress, the pharmacist will continue to  
12 be faced with professional emphasis on knowledge, inte-  
13 grity, judgment, honesty, dependability, vested authority  
14 and accepted responsibility. These prerequisites of a  
15 profession are placed daily at the disposal of the general  
16 public for their protection .... More and more, the public  
17 service role of the pharmacist is depending not so much on  
18 what he does as upon what he knows".

19               Only certain drugs are, by legislation,  
20 restricted to prescription-only distribution. Many other  
21 drugs and preparations are voluntarily withheld from  
22 over-the-counter sale, due to their particular nature of  
23 metabolic action. At the same time, there are many drugs  
24 available for over-the-counter sale upon the demand of the  
25 patient, and such packaged preparations are sold with a  
26 minimum of responsibility attached to the person who sells  
27 them, in that the purchaser has made a free choice, either  
28 based on self-diagnosis, or on the verbal advice of a  
29 physician. In such instances, the pharmacist assumes none  
30 of the activities outlined in the foregoing, nor can he





1 accept responsibility for the purchaser's choice, other  
2 than through the giving of advice related to his knowledge  
3 of the ingredients of the preparation, or related to  
4 information made known to him which would cause him to  
5 suggest that the potential purchaser might better seek  
6 advice as to his state of health.

7 Quite properly, the prescription, whether  
8 for a legislatively restricted preparation or not, must  
9 be handled in accordance with all procedures outlined, as  
10 it is, in the opinion of the physician, patient and phar-  
11 macist, an order to the effect that a particular patient  
12 be supplied with a specific quantity of a certain drug or  
13 mixture of drugs for use in accordance with definite  
14 directions.

15 THE CHAIRMAN: Mr. Turnbull, we now come to  
16 Prescription Prices. I think the next three or four  
17 headings all relate to that - Prescription Prices; An  
18 Examination of the Cost of Prescription Services; Histori-  
19 cal Trend in Costs; General Economic Factors; Factors  
20 Affecting the Real Per Capita Cost of Prescriptions in  
21 Constant Dollars in Canada - there is quite a series of  
22 that nature.

23 MR. TURNBULL: They are all more or less  
24 related to the one.

25 THE CHAIRMAN: They run for quite a number  
26 of pages.

27 MR. TURNBULL: Almost to the conclusion,  
28 sir.

29 THE CHAIRMAN: I think perhaps we had better  
30 adjourn at this point.



1 MR. COOK: I should mention, and I am not  
2 suggesting a change should be made for this reason, but  
3 a number of the executives of the Association are required  
4 by their own affairs to leave tomorrow evening. I don't  
5 know whether that makes any difference.

6 THE CHAIRMAN: They will be here tomorrow?

7 MR. TURNBULL: Some of them.

8 MR. COOK: As they all have to leave after  
9 tomorrow you might want to consider sitting a bit longer.

10 THE CHAIRMAN: I shouldn't think there is  
11 any difficulty in completing the reading in the morning.

12 MR. COOK: I don't know how long my friends'  
13 examinations will be.

14 MR. FRAWLEY: I don't think any of my  
15 friend's clients are going to wait for my examination.  
16 I don't flatter myself.

17 THE CHAIRMAN: Surely you are not being  
18 suddenly that modest?

19 MR. FRAWLEY: They will wait for Mr. Mac-  
20 Leod's, no doubt.

21 THE CHAIRMAN: I would think we would  
22 finish reading tomorrow morning without any difficulty.  
23 There is quite a bit, but I don't think there will be as  
24 many questions on the part of the Commission. It might  
25 not be difficult to get through. That would leave half  
26 the day for questioning and it might spill a little into  
27 Thursday.

28 MR. COOK: I recall that somebody else had  
29 been fixed for tomorrow.

30 THE CHAIRMAN: Not definitely fixed. We



1 we're told that Dr. Best could be here at 4 o'clock tomorrow  
2 afternoon, whether that is the only time he can appear or  
3 if he can come Thursday morning we don't know. We could  
4 go a little further.

5 MR. COOK: I didn't suggest that. I thought  
6 I should mention the fact in case the Commission thought  
7 it would have some significance.

8 THE CHAIRMAN: We would certainly like your  
9 people to be here if they feel it is necessary. I thought  
10 we would probably get almost to the end, if not quite to  
11 the end tomorrow, in any event. Perhaps I am being opti-  
12 mistic. This seemed to me to be quite a good place to  
13 stop because the next item, I thought, would take quite a  
14 long time.

15 MR. COOK: I thought it was a matter I  
16 should bring to your attention.

17 THE CHAIRMAN: It just happens to be quite  
18 a series of pages. There is a good deal of reading to be  
19 done before we can get to the end of this particular topic.  
20 I think, perhaps, we had better adjourn until tomorrow.  
21 There doesn't seem to be any very serious problem in it  
22 as far as we can guess at this time, and we hope we are  
23 right.

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25 --- Whereupon the hearing adjourned until 10 a.m.,  
26 Wednesday, October 25th, 1961.

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